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

CHILD INTAKE FORM

TO BE COMPLETED BY PARENT OF LEGAL GUARDIAN Today's Date: _____

PARENT 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:
EMPLOYMENT / INSURANCE INFORMATION			
Employer Name:	Occupation:		Work Phone:
Insurance ❒ Yes ❒ No	Name of Insurance Company:		
Emergency Contact Name (not a household member):			**Telephone Number:**
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: $
If you are unemployed how do you support yourself or your family?			

Other People Living in the Household

Name	Sex	Date of Birth	Age
	❒ M ❒ F		
	❒ M ❒ F		
	❒ M ❒ F		
	❒ M ❒ F		

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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: _____

FINANCIAL AGREEMENT

Family Counseling Service Fees

Counseling fees at 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 per hour.

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

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.

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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.**

-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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CHILD DEMOGRAPHIC INFORMATION			
Client Name:		❒ Male ❒ Female	
Age (Yrs.): ❒ 0-5 ❒ 6-11 ❒ 12-17			
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			
Child's Biological Parents: Mother's Name:_____ Father's Name:_____			
Child's Legal Guardian:_____			
Child currently <u>lives with</u>: (biological family, relatives, foster care, etc.)			
Name	Sex	Relationship to Child	Age
	❒ M ❒ F		
	❒ M ❒ F		
	❒ M ❒ F		
	❒ M ❒ F		
List significant others <u>NOT</u> living with the child			
Name	Sex	Relationship to Child	Age
	❒ M ❒ F		
	❒ M ❒ F		
	❒ M ❒ F		
Past counseling received by child or other family member:_____ Date: _____ Reason: _____ _____ Outcome : _____ _____			

CHILD MEDICAL HISTORY

Child's medical doctor:

_____

Address: _____Phone: _____

Date of child's last medical examination:

_____

Family use (current and/or past) of any drugs, tobacco or alcohol/ Explain:

_____

_____

_____

_____

Describe including quantity and frequency of substance:

_____

_____

_____

Did biological mother smoke, use alcohol, drugs or medications during pregnancy? (List which substances including quantity and frequency.). Explain:

_____

_____

_____

Did biological mother have any problems during pregnancy or delivery? If so, describe those problems:

_____

_____

_____

Has the child experienced any of the following medical problems? Please check all that apply:

- ☐ Serious accident
- ☐ Head injury
- ☐ Eye/ear problems
- ☐ Convulsions/ seizures
- ☐ Other _____
- ☐ Hospitalization
- ☐ High fever
- ☐ Meningitis
- ☐ Loss of consciousness
- ☐ Surgery
- ☐ Asthma
- ☐ Allergies
- ☐ Hearing problems

List current child medical problems or physical handicaps:

_____

_____

_____

List child's regular medications including quantity and frequency of dosage:

_____

_____

_____

_____

_____

CHILD EDUCATIONAL HISTORY

Child's School:_____

School Address: _____

Teacher's Name: _____

Current Grade: _____ Phone: _____

Teacher's current evaluation of child:

_____

_____

_____

_____

Other schools attended (including pre-school):

_____

_____

_____

Has the child ever repeated a grade: _____ If so, which one? _____

List special education services if applicable:

_____

_____

_____

_____

_____

_____

List child's problems at school, please check all that apply:

- ☐ Fighting
- ☐ Suspension
- ☐ Gang influence
- ☐ Lack of friends
- ☐ Learning disabilities
- ☐ Poor attendance
- ☐ Poor grades
- ☐ Incomplete homework
- ☐ Behavior problems
- ☐ Detention
- ☐ Drug/alcohol
- ☐ Other_____

BEHAVIOR FACTORS:

Excess. What misbehaviors does child currently display too often, too much or at the wrong times? (List all significant behaviors)

Deficits. What does child fail to do as often as you would like, as much as you would like or when you would like? (List all significant behaviors)

Assets. What does child do that you or others like?

List any other concerns about your child and/or family;

Has child ever experienced abuse? (Physical, emotional, sexual or verbal) If so, describe:

Has child ever made statements of wanting to seriously hurt self or another? Has child ever purposely hurt self or another? If yes to either question, describe situation:

Has child ever experienced serious emotional losses (deaths, separations, etc.)? If yes, explain:

What things currently stress child and/or child's family?

TREATMENT GOALS

What child problem behavior(s) do you want addressed first in therapy and how much positive change will satisfy you?

Signature of Parent or Legal Guardian _____ Date _____

Therapist Signature _____ Date _____