South Point Counseling Services, LLC

Empowering individuals, couples, and families

Intake Information Form

Client Name:	**Pronouns:**	Date:
Name of Parent or Legal Guardian (if under 18 years of age):		Client Date of Birth:
Referred By:		Client Social Security Number:
Address:		
City:	State:	Zip Code:

Cell Phone: Ok to leave message?	Home:	Work:	Other:
Email address:		May we e-mail you? (appointment reminders will be sent via email)	

Emergency Contact

Name & Relation:	Address:	
Cell Phone:	Home Phone:	Work:

Credit Card Information

Credit/Debit Card Number:	Expiration Date:	Security Code: (3 digit code on back of card)
Full Name on Credit/Debit Card:		

Insurance Information (if applicable):

Primary Insurance:	Insured's Name:
Insurance Plan Name:	Insured's Date of Birth:
Insured's ID Number:	Insured's Social Security Number:
Group Number:	Insured's Address:
Medicaid ID: (If Applicable)	Does your insurance require pre-approval?
Secondary Insurance: (If Applicable)	Secondary ID Number:
Secondary Group Number:	Secondary Insured's Date of Birth:

I have read and understand the enclosed clinic policies. Payment in full is due at the time of service. If I fail to cancel my appointment within the guidelines of the No Show Policy Disclosure, there will be a $50.00 fee which will be charged to my credit card. This credit card will also be used toward any unpaid account balances.

Signature: _____ **Date:** _____

South Point Counseling Services, LLC

Empowering individuals, couples, and families

Disclosure Statement and Informed Consent to Treatment

Your Rights and Responsibilities as a Psychotherapy Client

Therapy works best when it is a collaborative effort between the clinician and client and when the rights and responsibilities of each person is well defined. As a client, you have certain rights and responsibilities that you should be aware of since this is your therapy and our goal is your well-being. There are certain limitations to those rights that you should be familiar with. As a therapist, I also have responsibilities to you.

My Responsibilities to You as Your Therapist

Confidentiality: I am committed to keeping complete confidentiality of your therapy with the exception of the following instances described below. I cannot and will not tell anyone about whatever you tell me in therapy, or even the fact that you are in therapy with me without your prior written consent. It will be my responsibility to always act in a way as to protect your privacy, even when you allow me to share information about you with someone else. You can allow me to share information about you with whomever you want, and you can change your mind and revoke that permission whenever you want.

The following are exceptions to your right to confidentiality. I will let you know whenever I have to act on those exceptions.

1. If I find out that you have intention of harming someone, I will try to inform that person and warn them of your intentions. I will also contact the police and ask them to protect your intended victim.
2. If I have reason to believe that you are abusing a child or a vulnerable adult, or if you let me know of anyone else that is doing so, I will inform Child Protective Services or the police within 48 hours.
3. If I believe that you intend to harm yourself or are in danger of hurting yourself, I will call the police, crisis team, or someone that can ensure your safety. I will discuss my decision with you and we will explore your options before I decide what must be done.
4. I may use and disclose your information in order to bill and collect payment for the services that you are receiving from me. I may also use your information to obtain payment from third parties that may have been identified by you as responsible for your bill.
5. Please be advised that even though we make every effort to protect your information when using electronic communication such as e-mail, computer, cell phone, or fax, I cannot guarantee that there will not be any interception of it by someone else.
6. If you are filing a complaint or are a plaintiff in a lawsuit where your mental health information is needed, you will already have waived your right to the confidentiality of your records in the context of the complaint or lawsuit. Even though that might be the case, I will make every effort not to release your records unless you authorize me to do so. Please be aware that I may not always be able to do so.

Your Rights as a Psychotherapy Client

1. You have the right to ask questions about anything that happens in therapy. I will always be willing to discuss how and why I have decided to do what I am doing and look at different alternatives that might work better. You are welcome to let me know of an approach that you think will be helpful. You can ask me about my training and to transfer you to someone else if you are not comfortable with me. You are free to leave therapy at any time.
2. You have the right and responsibility to let me know if you are not in agreement with my treatment plan. At any time during therapy, you are encouraged to let me know if there is anything that you don't like or feel comfortable with, and if there is something else that you would like. Your input, no matter what it is, is very important to me.

3. You have the right to confidentiality and safe treatment. You have the right to be treated with respect and dignity.

Your Responsibilities as a Psychotherapy Client

1. You are responsible for coming to therapy on time and at the time that we have scheduled for you. If you are late, we will end on time and not run over into the next person's session. If you miss a session or cancel it with less than 24 hours, you will be charged a no-show fee of $50.00. Most places charge you for the price of the whole session. We choose to charge you only $50.00 but warn you that this fee will apply even in cases of emergency. All cancelations must be made within a 24-hour period for appointments Tuesday through Saturday. Appointments on Monday must be cancelled by 5:00 PM the Friday prior. This fee will be charged to the client or parent only and not the insurance company or the bishop. Payment will be immediately charged out of your credit card when possible or by the time of your next session.

2. You are responsible for supervising your children at all times while in the office. Please bring an adult with you to watch your children if you are going to be in a session. When waiting for therapy with your children, please be aware that they should not jump up and down or run around the office since we have other therapists providing therapy and this would be disruptive to our clients in the office.

3. You are responsible for paying for your session or your child's session at the beginning of each session unless we have made other arrangements in advance. South Point Counseling Services' fee is $160.00 for a 55-minute session and $195.00 for the initial assessment. If your account becomes past due, and collection becomes necessary, I will give your name and the amount due to a collection agency. In this case, you will be responsible for payment of an additional 33.3% collection fee and all legal collection fees, with or without suit, including attorney fees and court fees. When requested, we can assist in billing for insurance or authorized payment from your bishop or other sources. You should be aware that insurance companies require diagnostic labels and in cases where your diagnosis is not payable by your insurance, you will be responsible for the payment. Furthermore, some insurances require that you contact them for pre-authorization. It is your responsibility to obtain approval from your insurance and keep track of the number of authorized sessions. If services are provided to you without insurance approval, you will be responsible for payment.

Complaints:

If there is anything that you are not satisfied with in your therapy, I would hope that you can talk to me about it. I will take your criticism very seriously and with care and respect. If you don't feel comfortable talking to me about it, you can contact Roselene Dalanhese, our clinical director. She will be happy to assist you in finding another therapist that might be a better fit for you or addressing your concerns.

Client Consent to Psychotherapy:

I have read this statement. I had sufficient time to be sure that I considered it carefully, asked any questions that I needed to, and understand it. I consent to the use of a diagnosis in billing, and to the release of that information to my insurance company if I request so. I agree to pay the amount described in this statement at the beginning of each session. I agree to have my credit card billed for any no-show fees for sessions which I have not given a 24-hour prior notice cancelation and for any outstanding unpaid balance by my insurance. I understand my rights and responsibilities as a client, and my therapist's responsibilities to me.

I agree to undertake therapy with _____

Print Client's name: _____

Client Signature: _____ Date: _____

Parent/Guardian Signature (if applicable): _____ Date: _____

South Point Counseling Services, LLC

Empowering individuals, couples, and families

Consumer Rights Disclosure

As a state licensed program, our clinic is required to comply with all consumers rights. As a consumer, you to have the right to:

-Privacy of information for current and closed records,

-Understand the reasons for involuntary termination (failure to make payments and unwilling to engage in treatment plan) and criteria for re-admission (pay any outstanding balance, be evaluated again, and comply with treatment recommendations).

-Understand your consumer rights as outlined on this form and responsibilities (be engaged in treatment) in the development and implementation of an individual treatment plan,

-Be informed of the approximate duration of treatment (generally between 12 to 24 sessions) and desired outcome of recommendations in the treatment plan,

-Be aware of fees that are expected to be paid when services are rendered ($195 for the first session or assessment and $160 for the subsequent sessions).

-Freedom from discrimination,

-Be treated with dignity,

-A nicotine free facility in accordance with the Utah Clean Air Act (smoking is not allowed inside of this facility or within 25 feet),

-Obtain emergency mental health services during periods outside our normal operating hours by calling the University of Utah Crisis Line at 801-587-3000,

-File a grievance or complaint by contacting our Clinical Director Roselene Dalanhese at 801-403-7345 and/or the Utah Department of Human Services at 801-538-4242 or at hslic.utah.gov.

_____ _____

Signature Date

South Point Counseling Services, LLC

Empowering individuals, couples, and families

Payment and Insurance Agreement

Payment:

Whether or not I have insurance, I understand copayments are due at the time of service. South Point Counseling Services will assist me in filing any claims, but I am the one responsible for the balance. I will pay the full amount that the Billing Department has verified with my insurance. It is possible that my insurance company may provide South Point's Billing Department with inaccurate information, which may change the cost of my appointment. I am responsible for the amount not paid by my insurance. South Point Counseling Services encourages me to verify the benefits prior to services being rendered. If my Explanation of Benefits (EOB) indicates an overpayment has been made, South Point Counseling Services will initiate a refund to me. I acknowledge that I understand two appointments in one day may not be covered by my insurance and I will be responsible for any balance.

Initials: _____

Insurance:

• **Verification and estimation of benefits:** South Point Counseling Services verifies all client benefits as a courtesy. It is NOT a guarantee that my insurance will cover their estimated portion, which will result in me owing more than originally anticipated. Even though South Point Counseling will give me an estimate, I understand it is my insurance company that determines the amount paid and what is left to patient responsibility. I am aware that if I choose to receive services via telehealth, I am responsible to verify if this benefit is covered by my insurance.

Initials: _____

• **Insurance Information:** I verify that all insurance information I have provided is correct and current to avoid any claim denials or timely filing limits. It is my responsibility to verify that South Point Counseling Services is in network with my plan.

Initials: _____

• **Divorced Parents:** The parent who signs the **Intake Information Form** is the responsible party for all billing and balances. I am aware that all documents regarding custody agreements will need to be provided at the time of the first appointment. If the custody agreement states the cost of appointments are divided amongst both parents, the parent who makes payment will need to bill the other party directly.

Initials: _____

Signature: _____ **Date: _____**

South Point Counseling Services, LLC

Empowering individuals, couples, and families

No Show Policy Disclosure

The therapists at South Point Counseling Services strive to provide all clients with the best possible care. A huge component to the overall success of your treatment with us, is your commitment to the treatment plan you will create with your therapist. That commitment includes attendance to your scheduled appointments.

We require prior cancellation to all missed appointments. Most offices will charge you the full cost of your appointment; however, **you will be charged only $50.00 for consultations, $50 for medication management and $150 for tests, if you do not call and or email us within the time frame outlined in our policy.** All missed appointment fees will be charged to the credit/debit card on file and will not be refunded. If you do not have a working card on file, the missed appointment fee will be added to your account and will be due along with any other co-pay or co-insurance at your next appointment.

Our policy for cancellations is as follows:

- All appointments scheduled on Monday must be cancelled by 5:00 PM on the Friday prior.
- All appointments Tuesday through Saturday must be cancelled with a full 24-hour notice.
- **All testing appointments require a full 72-hour notice.**
- Regardless of an emergency, you will be charged.
- All of our clinicians have a waiting list for appointments. If your cancelled appointment can be filled, you will not be charged. Filling an appointment usually requires 24-hour notice, but we will always contact clients on your therapist's waiting list and offer them the opening.
- All clients who are put on a regular re-occurring schedule, must cancel their appointment within the guidelines of our policy. After the second no show occurrence, you will be taken off your therapist's schedule until you contact us to reschedule.
- Clients taken off a therapist's re-occurring schedule, forfeit their regular time slot and may not be given the same appointment time. You must then call our office to schedule a new appointment. If an opening is not available, we will call you back as soon as there is an opening.
- Any questions or concerns about this policy, can be directed to our office manager or clinical director.

Our time is as valuable as yours. Thank you in advance for helping us provide reliable treatment to our clients.

(Acknowledgment of disclosure)

I _____(patient name/guardian signature) have read the No Show Policy Disclosure and agree to provide the required advanced notice to South Point Counseling Services in the event that I must miss an appointment.

_____Date

South Point Counseling Services, LLC

Empowering individuals, couples, and families

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been out of practice for years. This form is a "friendly" version. A more complete text is available upon request.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. WE balance these needs with our goal of providing you with quality professional services and care additional information is available from the U.S. Department of Health and Human Services: www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
3. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
4. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
5. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
6. We agree to provide patients with access to their records in accordance with state and federal laws.
7. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
8. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____date _____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward. I have also been offered a copy of this HIPAA form.

South Point Counseling Services, LLC

Empowering individuals, couples, and families

Subpoena Agreement

I understand that should I or a third party subpoena any therapist who is part of South Point Counseling Services as a factual case witness or involve him/her in court-related processes, he/she will charge me a retainer fee of $1,000.00 and a charge of $200.00 every hour he/she is involved in case preparation, research, paperwork, phone calls, travel, witness time, etc.

I understand that if I do issue any therapist who works for South Point Counseling Services a subpoena with or without his/her approval (see above) that my subpoena may be directly turned over to his/her attorney and a bill will be rendered for an immediate attorney's retainer fee. I will also be billed accordingly by him/her and I agree to pay all attorney's fees plus my therapist's fees as invoiced.

I understand that if a child who is in therapy has parents who are divorced and/or part of a joint custody arrangement, I must furnish South Point Counseling Services, LLC with a copy of the custody agreement/divorce decree.

_____ _____

Signature Date

Biopsychosocial History—Children and Adolescents

Client's name: _____ Date: _____

Form completed by (if someone other than client): _____

If you need any more space for any of the following questions, please use the back of the sheet.

Primary reason(s) for seeking services:

____Anger management	____Anxiety	____Coping	____Depression
____Eating disorder	____Fear/phobias	____Mental confusion	____Sexual concerns
____Sleeping problems	____Addictive behaviors	____Alcohol/drugs	____Hyperactivity

____Other mental health concerns (specify): _____

Do you believe the child is suicidal at this time? ___Yes ___No

If yes, explain:

BEHAVIORAL/EMOTIONAL

Please check any of the following that are typical for your child:

___Affectionate	___Frustrated easily	___Sad
___Aggressive	___Gambling	___Selfish
___Alcohol problems	___Generous	___Separation anxiety
___Angry	___Hallucinations	___Sets fires
___Anxiety	___Head banging	___Sexual addiction
___Attachment to dolls	___Heart problems	___Sexual acting out
___Avoids adults	___Hopelessness	___Shares
___Bedwetting	___Hurts animals	___Sick often
___Blinking, jerking	___Imaginary friends	___Short attention span
___Bizarre behavior	___Impulsive	___Shy, timid
___Bullies, threatens	___Irritable	___Sleeping problems
___Careless, reckless	___Lazy	___Slow moving
___Chest pains	___Learning problems	___Soiling
___Clumsy	___Lies frequently	___Speech problems
___Confident	___Listens to reason	___Steals
___Cooperative	___Loner	___Stomachaches
___Cyber addiction	___Low self-esteem	___Suicidal threats
___Defiant	___Messy	___Suicidal attempts
___Depression	___Moody	___Talks back
___Destructive	___Nightmares	___Teeth grinding
___Difficulty speaking	___Obedient	___Thumb sucking
___Dizziness	___Often sick	___Tics or twitching
___Drug dependence	___Oppositional	___Unsafe behaviors
___Eating disorder	___Overactive	___Unusual thinking
___Enthusiastic	___Overweight	___Weight loss
___Excessive masturbation	___Panic attacks	___Withdrawn
___Expects failure	___Phobias	___Worries excessively
___Fatigue	___Poor appetite	___Other:
___Fearful	___Psychiatric problems	_____
___Frequent injuries	___Quarrels	_____

What are your goals for the child's therapy?

What family involvement would you like to see in the therapy?

COUNSELING/PRIOR TREATMENT HISTORY

Information about child/adolescent (past and present):

	Yes	No	When	Where	Reaction or overall experience
Counselling/Psychiatric treatment	___	___	_____	_____	_____
Suicidal thoughts/attempts	___	___	_____	_____	_____
Drug/alcohol treatment	___	___	_____	_____	_____
Hospitalizations	___	___	_____	_____	_____

MEDICAL/PHYSICAL HEALTH

___Abortion
___Asthma
___Blackouts
___Bronchitis
___Cerebral palsy
___Chicken pox
___Congenital problems
___Croup
___Diabetes
___Diphtheria
___Dizziness
___Earaches
___Ear infections
___Eczema
___Encephalitis
___Fevers
___Hay fever
___Heart trouble
___Hepatitis
___Hives
___Influenza
___Lead poisoning
___Measles
___Meningitis
___Miscarriage
___Multiple sclerosis
___Mumps
___Muscular dystrophy
___Nosebleeds
___Other skin rashes
___Paralysis
___Pleurisy
___Pneumonia
___Polio
___Pregnancy
___Rheumatic fever
___Scarlet fever
___Seizures
___Severe colds
___Severe head injury
___Sexually transmitted disease
___Thyroid disorders
___Vision problems
___Wearing glasses
___Whooping cough
___Other
_____
_____

List any current health concerns: _____

List any recent health or physical changes:

Does the child/adolescent use or have a problem with alcohol or drugs? ___Yes ___No

If yes, describe: _____

Current prescribed medications	Dose	Date	Purpose	Side effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

FAMILY HISTORY

PARENTS

With whom does the child live at this time? _____

Are parent's divorced or separated? _____

If yes, who has legal custody? _____

Were the child's parents ever married? ____Yes ____No

Is there any significant information about the parents' relationship or treatment toward the child which might be beneficial in counseling? ____Yes ____No

If yes, describe: _____

Client's Mother

Name: _____Age: _____ Occupation: _____ ____FT ____PT

Where employed: _____ Work phone: _____

Mother's education: _____

Is the child currently living with mother? ____Yes ____No

_____Natural parent ____Stepparent ____Adoptive parent ____Foster home ____Other (specify): _____

Is there anything notable, unusual or stressful about the child's relationship with the mother?

____Yes ____No If yes, please explain: _____

How is the child disciplined by the mother? _____

CLIENT'S FATHER

Name: _____ Age: _____ Occupation: _____ ___FT ___PT

Where employed: _____ Work phone: _____

Father's education: _____

Is the child currently living with father? ____Yes ____No

____Natural parent ____Stepparent ____Adoptive parent ____Foster home ____Other (specify): _____

If there anything notable, unusual or stressful about the child's relationship with the father?

____Yes ____No If yes, please explain:

How is the child disciplined by the father? _____

Client's Siblings and Others Who Live in the Household

Name of Siblings	Age	Gender	Lives	Quality of relationship with the client
_____	___	___F ___M	___home ___away	___poor ___average ___good
_____	___	___F ___M	___home ___away	___poor ___average ___good
_____	___	___F ___M	___home ___away	___poor ___average ___good
_____	___	___F ___M	___home ___away	___poor ___average ___good

Others living in the household	Gender	Relationship (e.g., cousin, foster child)	
_____	___F ___M	_____	___poor ___average ___good
_____	___F ___M	_____	___poor ___average ___good
_____	___F ___M	_____	___poor ___average ___good
_____	___F ___M	_____	___poor ___average ___good

Comments:

Has the child/adolescent experienced death? (friends, family pets, other) ____Yes ___No

At what age? ____ If yes, describe the child's/adolescent's reaction:

EDUCATION

Current school: _____ School phone number: _____

Type of school: _Public _Private _Home schooled _Other (specify): _____

In special education? _Yes _No If yes, describe: _____

In gifted program? _Yes _No If yes, describe: _____

Has child ever been held back in school? _Yes __No If yes, describe: _____

Which subjects does the child enjoy in school? _____

Which subjects does the child dislike in school? _____

What grades does the child usually receive in school? _____

Have there been any recent changes in the child's grades? ____Yes ____No

If yes, describe: _____

Has the child been tested psychologically? ___Yes ___No

If yes, describe: _____

FEELINGS ABOUT SCHOOLWORK:

___Anxious ___Passive ___Enthusiastic ___Fearful

___Eager ___No expression ___Bored ___Rebellious

___Other (describe): _____

APPROACH TO SCHOOLWORK:

___Organized ___Industrious ___Responsible ___Interested

___Self-directed ___No initiative ___Refuses ___Does only what is expected

___Sloppy ___Disorganized ___Cooperative ___Doesn't complete assignments

___Other (describe): _____

PERFORMANCE IN SCHOOL (PARENT'S OPINION):

____Satisfactory ____Underachiever ____Overachiever

____Other (describe): _____

CHILD'S PEER RELATIONSHIPS:

___Spontaneous ___Follower ___Leader ___Difficulty making friends

___Makes friends easily ___Longtime friends ___Shares easily

___Other (describe): _____

Who handles responsibility for your child in the following areas?

School: ___Mother ___Father ___Shared ___Other (specify): _____

Health: ___Mother ___Father ___Shared ___Other (specify): _____

Problem behavior: ___Mother ___Father ___Shared ___Other (specify): _____

OTHER

Does the child have any hobbies or general activities?

Have there been any other significant changes or events in your child's life? (family, moving, fire, etc.)

___Yes ___No If yes, describe:

Any additional information that you believe would assist us in understanding your child/adolescent?

Your name:_____ **Therapist's name:** _____ **Date:**_____

Evaluation of Therapy Session

Instructions. Use checks (√) to indicate how you felt about your recent therapy session.

Please answer all the items.

	0 - Not at all true	1 - Somewhat true	2 - Moderately	3 - Very true	4 - Completely true
Therapeutic Empathy					
1. My therapist seemed warm, supportive, and concerned.					
2. My therapist seemed trustworthy.					
3. My therapist did a good job of listening.					
4. My therapist treated me with respect.					
5. My therapist understood how I felt inside.					
Helpfulness of the Session					
6. I was able to express my feelings during the session.					
7. I talked about the problems that are bothering me.					
8. The technique we used was helpful.					
9. The approach my therapist used made sense.					
10. I learned some new ways to deal with my problems.					
Satisfaction with Today's Session					
11. I believe the session was helpful.					
12. Overall, I was satisfied with today's session.					
Your Commitment					
13. I plan to do therapy homework before the next session.					
14. I intend to use what I learned in today's session.					
Negative Feelings during the Session					
15. At times, my therapist didn't seem to understand how I felt.					
16. At times I felt uncomfortable during the session.					
17. I didn't always agree with my therapist.					
Difficulties with the Questions					
18. It was hard to answer some of these questions honestly.					
19. Sometimes my answers didn't show how I really felt inside.					
20. It would be too upsetting for me to criticize my therapist.					

What did you like ***the least*** about the session? _____

What did you like ***the best*** about the session? _____

Did the clinician explain how group therapy can aid in your treatment? Did he/she go over the groups available at South Point Counseling Services?_____