



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:	Home:	Work:	Other:
Ok to leave message?			
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: _____



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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: _____



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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



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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: _____



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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



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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.



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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
Counseling/Psychiatric treatment	___	___	___	___	___
Suicidal thoughts/attempts	___	___	___	___	___
Drug/alcohol treatment	___	___	___	___	___
Hospitalizations	___	___	___	___	___

MEDICAL/PHYSICAL HEALTH

- | | | |
|-------------------------|------------------------|----------------------------------|
| ___ Abortion | ___ Hay fever | ___ Pneumonia |
| ___ Asthma | ___ Heart trouble | ___ Polio |
| ___ Blackouts | ___ Hepatitis | ___ Pregnancy |
| ___ Bronchitis | ___ Hives | ___ Rheumatic fever |
| ___ Cerebral palsy | ___ Influenza | ___ Scarlet fever |
| ___ Chicken pox | ___ Lead poisoning | ___ Seizures |
| ___ Congenital problems | ___ Measles | ___ Severe colds |
| ___ Croup | ___ Meningitis | ___ Severe head injury |
| ___ Diabetes | ___ Miscarriage | ___ Sexually transmitted disease |
| ___ Diphtheria | ___ Multiple sclerosis | ___ Thyroid disorders |
| ___ Dizziness | ___ Mumps | ___ Vision problems |
| ___ Earaches | ___ Muscular dystrophy | ___ Wearing glasses |
| ___ Ear infections | ___ Nosebleeds | ___ Whooping cough |
| ___ Eczema | ___ Other skin rashes | ___ Other |
| ___ Encephalitis | ___ Paralysis | _____ |
| ___ Fevers | ___ Pleurisy | _____ |

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

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

0 - Not at all true	1 - Somewhat true	2 - Moderately	3 - Very true	4 - Completely true
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Instructions. Use checks (√) to indicate how you felt about your recent therapy session.

Please answer all the items.

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? _____