



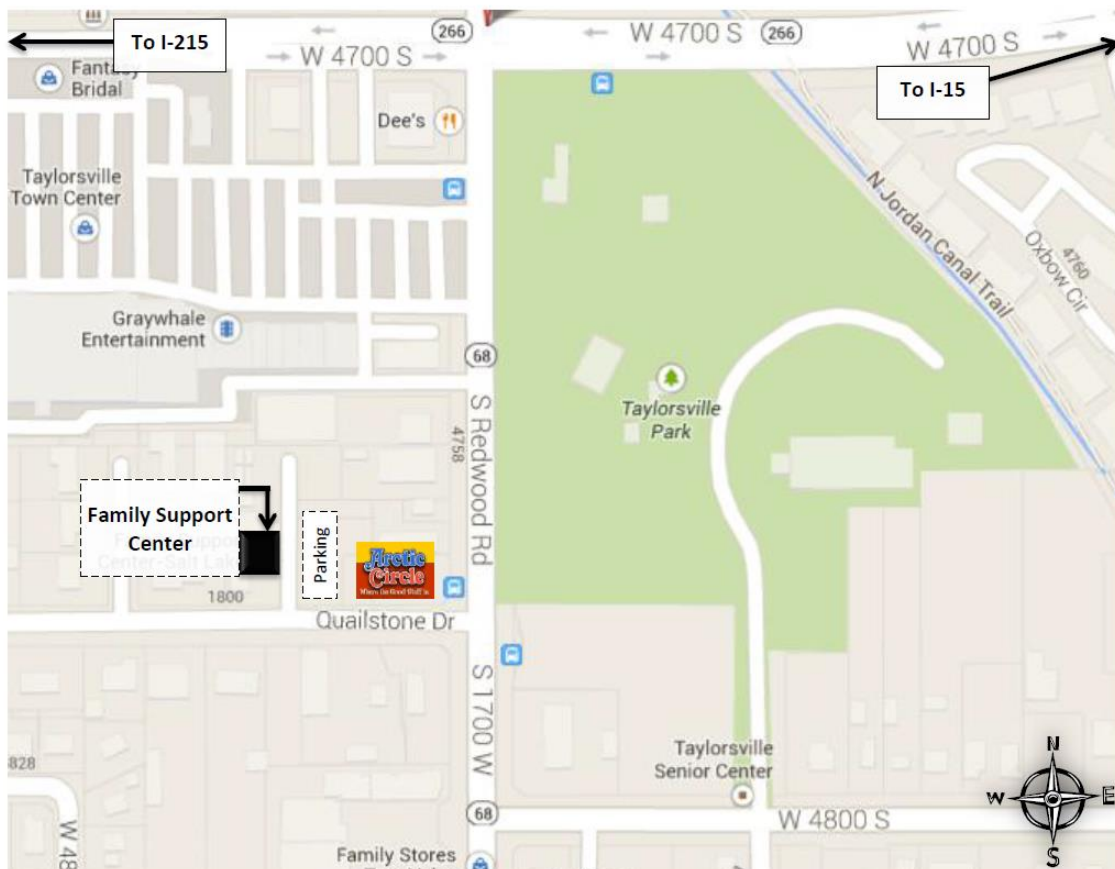
Please print and fill out the following paperwork prior to arriving for your first session.

If you do not bring the paperwork completed with you, you will be asked to fill out new paperwork on-site before a therapist can see you. Plan to arrive at least 30 minutes prior to your appointment time.

**Thank you,
FSC Clinical Staff**

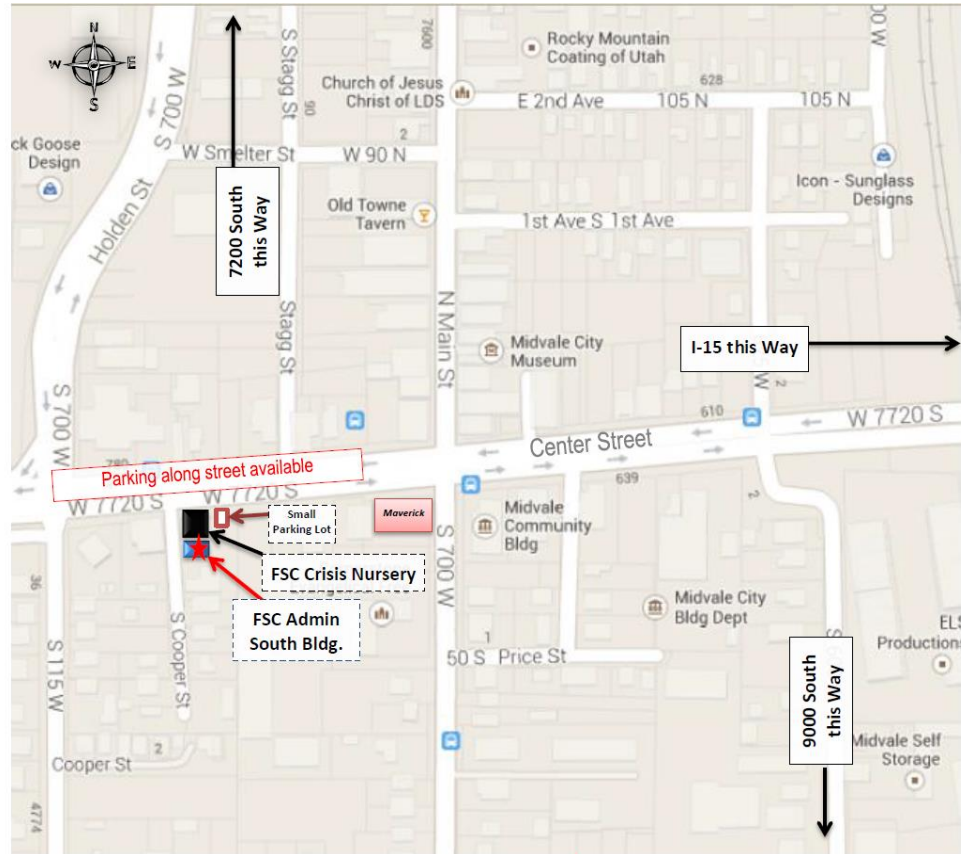
Family Support Center Administrative Office is located at:
1760 West 4805 South
Taylorsville, Utah 84129
801-955-9110

(We are just South 4700 South and Redwood Road, in the red brick building directly behind the Arctic Circle.)



Additional Family Support Center Locations with Clinical Offices

Admin South Building
777 West Center Street
(7720 South)
Midvale, Utah 84047
801-255-6881





Client Intake Packet for Minors

Dear Guardian:

Upon admission for treatment at the Family Support Center, a client file will be started for your minor. This file will document the dates and nature of all services provided to you and allows your therapist to carefully monitor your progress in treatment. A clinical diagnosis and treatment objectives will be developed and recorded, as will the results of any tests administered, family/social history and relevant medical history.

Information placed in your file is highly confidential and is carefully protected by the Agency. Non-HIPPA protected information is released to other agencies or professionals only on your express written request and only when it is in your best interest that we do so. When the client is a child under the age of 18, a request to release information must be signed by custodial parent or legal guardian.

You have the right to review non-HIPPA protected contents of your file. You may request copies of treatment plans, agency assessments and agency evaluations for a charge of \$25.00. Original documents remain the property of the agency. You will be responsible for requesting copies in which you have an interest prior to the file destroy date listed below.

INFORMED CONSENT

Policy and practices of the Family Support Center are as follows:

- All services will be delivered directly or supervised by a licensed mental health professional or by a properly supervised student.
- The Family Support Center provides professional training opportunities and to that extent, client cases may be reviewed in consultation and training of agency staff members.
- Clinical records will be kept confidential except in situations of harm or threatened harm to child or others. In those cases, information may be released to Child Protective Services, law enforcement, and with possible release to prosecutors, defense attorneys or the court.
- In the event that I refuse to release the information, I understand that such records and videotapes maybe reviewed pursuant to court order.
- I understand that the agency will take steps to prevent harm in cases of immediate danger or to prevent a crime.
- Insurance companies or agencies that assist in paying for the services are entitled to access dates and type of services provided.
- Clinical records retained by the Family Support Center will be destroyed after a period of twelve years for adults. Records of child clients will be retained until the child reaches the age of 22.
- As mandated reporters, at any time abuse or neglect is suspected, it will be reported.
- To avoid ethical dilemmas agency staff members are not allowed to friend clients, including through electronic media.

Please indicate by your signature below that you have read and understand the above conditions under which treatment services are offered, and had the opportunity to ask questions.

APPROVAL (Please initial below)

_____ 1. Provide individual, family or group treatment as appropriate

_____ 2. Conduct a psychological and/or corroborative assessment

Parent/Guardian

Date

Assigned Clinician

Date

CONFIDENTIAL CLIENT INTAKE INFORMATION FOR MINORS

CLIENT'S NAME: _____ DATE OF BIRTH: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
SOCIAL SECURITY #: _____ - _____ - _____ Any Disabilities: _____

RACE: Caucasian African American Asian Native American/Alaskan Hawaiian/Pacific Islander
ETHNICITY: Hispanic Other/Multi Racial EDUCATION: Highest Grade or Degree Completed _____
GENDER: Male Female

HOUSEHOLD AND GUARDIAN INFORMATION

Are you currently living in a place not meant for human habitation, a safe haven, or in an emergency shelter? ___ Yes ___ No
A. Have you been continuously, for at least 12 months, or 4 separate times in the last 3 years? ___ Yes ___ No
B. *If yes, has the combined occasions equaled to at least 12 months? ___ Yes ___ No
INCOME LEVEL: \$0 - 14,999 \$15,000 - 19,999 \$20,000 - 24,999 \$25,000 - 35,000 \$36,000 - 45,999 \$46,000+
Family Structure: # Of Adults In Home _____ # Of Children In Home _____
Who referred you to the FSC? _____
(Person's Name) (Name of agency/position)

CUSTODIAL PARENT OR LEGAL GUARDIAN:

Name: _____ Relationship to Minor: _____
Address (City/State/Zip): _____
Home Phone: _____ Work Phone: _____ Alternate Cell Phone: _____

EMERGENCY CONTACT FOR GUARDIAN:

Name: _____ Relationship to you: _____
Address (City/State/Zip): _____
Home Phone: _____ Work Phone: _____ Alternate Cell Phone: _____

INSURANCE INFORMATION:

Do you have Insurance? Yes___ No___ If Yes, Carrier: _____
Do you have mental health benefits? Yes___ No___ Phone Number of Insurance Company _____
Name of Insured _____ Policy # _____ Insured Date of Birth _____
Address (if different from above) _____

MESSAGE PERMISSION FORM

In order to provide better service to you, we request your help in providing us with your preferences regarding telephone contact. Please indicate which means of relaying a message to you would be acceptable.

In the event that Family Support Center employees cannot reach me at the telephone number listed above, I give them permission to leave messages:

On my answering machine	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Text	Yes <input type="checkbox"/>	No <input type="checkbox"/>
With my spouse/partner	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Email	Yes <input type="checkbox"/>	No <input type="checkbox"/>
With whoever answers	Yes <input type="checkbox"/>	No <input type="checkbox"/>			

If necessary I can be contacted at my work # _____

Other, please explain: _____

OTHER PARENT IF NOT LISTED ABOVE:

NAME(S): _____ DATE OF BIRTH: _____
ADDRESS: _____ PHONES: H _____ W _____ C _____
CITY, STATE: _____ ZIP: _____ SOCIAL SECURITY #: _____ - _____ - _____
EMPLOYMENT: _____

What type of therapy are you seeking for your child? Check those that apply: Individual__ Family__ Group__

Have they been in therapy before? Yes No

If yes, with whom? _____

When: _____ Reason for being seen: _____

Is the child currently taking any medications? Yes No

If yes, please list below:

Medication	Reason for Taking

Signature

Date

Parent Or Parent's Designee must remain on site for child's clinical sessions

For minor clients, the minor's parent, or a person identified by the parent as their minor's approved caregiver must remain on the Family Support Center premises throughout the entire time of a minor's clinical session. No minor will be provided a clinical service if their caregiver is unable to remain on-site. If a minor is 16 years old or over and is able to transport themselves to the agency, an exception to this policy may be made.

I have read, understand, and agree to the above policy.

Print Name

Signature

Date

SLIDING FEE ELIGIBILITY FORM

CURRENT COST OF COUNSELING*

\$100.00 per hour (50 minutes) for individual therapy

\$100.00 per hour (50 minutes) for family therapy

**Additional fees will be charged for extended session times.*

Section 1: Income Listing

Enter the amount of money received monthly by you, your spouse or any other adult living in your home. Do not include earnings of any child under age 18. **Please provide documentation** (for example: pay stub, W2, court order of alimony).

Earned Income (for example: earned wages, self-employments, commissions): _____

Temporary income (for example: workman's compensation, unemployment): _____

Government subsidies (for example: social security, veterans pensions, disability income, TANF): _____

Child support or alimony: _____

Other income (indicate source): _____

Total monthly income: _____

Section 2: Expenses

List the amounts of any of the following expenses incurred and being paid monthly by you or any member of your household. Please provide documentation.

Child support or alimony paid monthly (Proof must be provided): _____

Monthly mortgage or rental payment: _____

Total Monthly Expenses: _____

Section 3: Applicant Declarations

I have completed this application to the best of my knowledge and understand that any false information provided herein may result in prosecution for fraud in obtaining social services.

If during the time I am receiving services **there is a change** in income or household composition, **I agree to report the change** to the Family Support Center where I made the application.

I also understand that **I must re-certify** this information bi-monthly.

Signature of Guardian

Date

OFFICE USE ONLY BELOW THIS LINE

Monthly Income: _____

Deductible Expenses (30%): _____

Adjusted Income: _____

Eligible: Yes No

Income Category: Extremely Low Very Low Low Moderate

Fee Assessed: _____

Signature of verifying staff member: _____ **Date:** _____

FEE AGREEMENT, PAYMENT & TWENTY-FOUR HOUR CANCELLATION POLICY

Fee collection is an important part of the Family Support Center's ability to offer affordable counseling services. Therefore:

1. Payment is due at time of service. I agree to pay my appointment fees at the time of each visit and to keep my account current. For those on Medicaid, you will not be charged except for a No Show which is not covered.
2. You are responsible for payment of your bill and for follow-up with insurance payment if applicable.
3. The Family Support Center's counseling program **requires a 24-hour notice of cancellation** if you are unable to keep your appointment. If you fail to give 24 hour notice of cancellation, you will be assessed a **no show/late cancel fee of \$50.00** for which you are solely responsible. Your insurance will not pay for these canceled sessions. This fee must be paid **before** your therapist is allowed to reschedule with you.
4. If you have two late cancels and/or no shows, your therapist will not be allowed to reschedule an appointment. Your name will be placed on the waiting list if you wish and you will be given referrals to other possible treatment providers. However, if you wish to continue services, all fees must be paid in full prior to continuance with the Family Support Center.
5. If you do not make payment for three sessions without making a payment arrangement with the billing department, your services will be terminated.
6. Any balances more than 120 days past due will incur an additional fee of 30% of your past due balance and will be referred to collections unless a payment arrangement has been made with the billing office.

If you have any questions, please call our office or speak to your therapist.

GUARDIAN AGREEMENT

I acknowledge that I have read and understand the above Payment and "No Show" Late Cancel Policies **and agree** to make payments to FSC for the professional services provided according to the Payment and Late Cancel Policies.

Guardian Name

Guardian Signature

Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I have read and understand the Family Support Center's notice of privacy practices brochure.

My signature below indicates that I have read this notice and agree to its terms. I also understand that I have the right to obtain a copy of this notice.

Guardian Signature

Date

CLIENT RIGHTS / FAIR HEARING / GRIEVANCE POLICY

I understand that if I am found not eligible for services from this agency, I have a right to appeal the decision at a Fair Hearing. I also understand that I have this right if services are stopped or if they are not made available to me with reasonable promptness. I understand that I may also register a complaint with the Executive Director of the agency.

You may also contact the Division of Child and Family Services (DCFS) at (801) 538-4100, and if you are a Medicaid client by contacting Optum Health at (877) 370-8953 ext. 63108.

1. Your information and records are confidential. Access to records will only be granted with written permission from you. Your records are kept in a secured area.
2. You have the right to participate in a safe environment. Any potentially harmful situation should be immediately reported to a *program director at Family Support Center*. Threats or violence will not be tolerated and may result in termination of services.
3. You have the right to be treated fairly, with dignity and respect. If you feel you are mistreated please follow the grievance procedure outlined below.
4. Smoking is not permitted in this office or near public entrances in accordance with the Utah Clean Air Act.
5. You have the right to be free from discrimination based on age, race, color, culture, religion, sexual orientation, or disability. If you feel you have been discriminated against, please follow the grievance procedure outlined below. *Family Support Center* complies with all applicable laws regarding discrimination. Any form of discrimination will not be tolerated.
6. Grievance Procedure: If you feel you have been mistreated or have any grievance, you have the right to be heard and have your issue addressed. Following are the steps to take:
 - a. You are first encouraged to address the problem directly with the offending person.
 - b. If you are unable to address the situation with them, please contact the Family Support Center Executive Director at (801) 955-9110 x101.
 - c. If you are unable to do one of the two above steps for any reason or the situation is not resolved, you should contact the referring parties (Insurance company, treatment center, doctor's office, etc.).
 - d. If you are still not satisfied, please contact any of the following agencies:

Department of Human Services (DHS)
Division of Licensing
(801) 538-4242
(801) 538-4553 (fax)
195 North 1950 West
Salt Lake City, UT 84116
[http://hslic.utah.gov/](http://hslic.utah.gov)

For Medicaid, Optum, or TANF Clients:
Utah Department of Workforce Services
Equal Opportunity/Customer Relations
(801) 526-4390 or (800) 331-4341
P.O. Box 45249
Salt Lake City, UT 84145-0249
<http://jobs.utah.gov/edo/eo.asp>

For Clinical Clients:
Utah Department of Commerce
Division of Occupational and Professional
Licensing
(801) 530-6630 or (866) 275-3675
P.O. Box 146741
Salt Lake City, UT 84114-6741
<http://www.dopl.utah.gov/investigations/complaint.html>

I have received a copy of the Clients Rights and Grievance Policy

Signature

Date