NORTHEASTERN COUNSELING CENTER
APPLICATION FOR SERVICE

08/2018

Patient Name (First, Middle, Last)	**Gender** M F	**Age**	**Date of Birth**	**Social Security #**
Mailing Address (Address, City, State, Zip)	**Phone #** **Home:** **Cell:**			
Physical Address (Address, City, State, Zip)	**Send Text Reminders to cell # above:** Yes_____ No_____	**Cell Phone Provider (Strata, AT&T, Sprint, etc.):**		
Emergency Contact (Name, phone #, relationship to patient)	**Parent/Guardian, if a minor** (Name, Phone, Relationship to patient)			
Yrs of Education	**Are you currently enrolled in an education program?** Yes No	**Primary language spoken if other than English: _____**		
Have you had previous mental health treatment at any of the following facilities: **Utah State Hospital** Yes No **Northeastern Counseling Center** Yes No **Other Mental Health Center** Yes No				
Tobacco use: Never Former Somedays Everyday Smokeless	**Age of first tobacco use _____**			
Have you ever served in the military? Yes No	**Are you pregnant?** Yes No			
Are you currently taking any of the following medications: Clozapine-Clozaril, Quetiapine-Seroquel, Olanzopine-Zyprexa, Risperdone-Risperdal (oral or Consta injection) or Ziprasidone-Geodon (oral or injection) Yes No				
Total # of people in the home _____	**Total # of minor children in the home _____**			

PLEASE CIRCLE ONE ANSWER IN EACH BOX BELOW

DISABILITY:	**RACE:**	**HISPANIC:**	**LIVING ARRANGEMENT:**
Blind	Native American: Tribe _____	Puerto Rican	Homeless or Shelter
Deaf	Asian	Mexican	Private Residence
Organic	African American	Cuban	Private Residence with Supervision
Ambulatory	White/Caucasian	Other Hispanic	Jail or Correctional Institution
Intellect	Alaskan Native (Aleut. Eskimo)	Not Hispanic Origin	24-Hour Residential
None	Native Hawaiian/Pacific Islander		Foster Care
	Other:		

MARITAL STATUS:	**PRESENTING PROBLEM:**	**REFERRAL SOURCE:**	
Married	Suicide Related	Individual/Self	Alcohol/Drug Abuse Care Provider
Divorced	Depression/Anxiety	Family or Friend	Mental Health Provider
Separated	DUI	School	Other Health Care Provider
Widowed	Mental Health	Employer/EAP	Division of Workforce Services
Never Married	Substance/Alcohol Use	DCFS	Justice Referral/Court Order
	IV Drug User	DSPD	Other Community Referral
	Other	Clergy	

EMPLOYMENT STATUS:

Employed Full-Time (35+ hours/week)	Inmate of an Institution
Employed Part-Time (<35 hours/week)	Homemaker
Supported/Transitional Employment	Retired
Disabled/Not In Workforce	Student
Other, not in labor force/not seeking work	Age 0-5
Unemployed/Seeking Work	

OFFICE USE ONLY

Contact Date & Time:	**Evaluation Date, Time and Clinician:**	**Credible ID:**	**Primary Clinician:**

Northeastern Counseling Center

Fee Information and Policy Agreement

Client Information

Last Name:	First Name:	Middle:

Party Responsible for Client (Payment)

Last Name:		First Name:		Middle
Address:			City:	
State:	Zip:	Phone: ( )		Birthday / /
Social Security No:		Relationship to Client:		

Source of Income	**Gross Monthly Amount**	For Office Use Only:
Employment		
Public Assist.		
Soc. Security		
Unemply/Work Comp		
Alimony/Child		
Other		
Total		
# of Dependents		

Private Insurance/Medicaid/Medicare Information

Insurance name:		Policy #:		Group #
Address:		City:	State:	Zip:
Name of Insured:		Insured's Birthday / /		Co-Pay $
Authorization #	# of Authorized Sessions	Approved Provider (s)		

Private Insurance/Medicaid/Medicare Information

Insurance name:		Policy #:		Group #
Address:		City:	State:	Zip:
Name of Insured:		Insured's Birthday / /		Co-Pay $
Authorization #	# of Authorized Sessions	Approved Provider (s)		

IMPORTANT: PLEASE READ BEFORE SIGNING

Northeastern Counseling Center, hereafter NCC, is a not for profit corporation. Every client is charged actual cost for services rendered. Although you are responsible for service received, a discount may be available to you. NCC can offer this discount to you since Federal and State funds help operate NCC.

In accordance with the NCC policy of setting an individual's fee for services according to his/her ability to pay, my fee has been set at $_____ per /hr. (minimum $5 charge). I also understand I will be billed $10 for broken appointments, as per Client Responsibilities #3 (reverse side). My fee for services will be reviewed periodically and adjusted to reflect my current ability to pay. It is understood that if I fail to make payments as per this agreement, NCC will take such legal action for collection of the balance due as is appropriate. Legal fees resulting from this action will be added to my balance due. I understand that since my fee usually does not cover the full cost of services, NCC will bill my insurance company or other third party payment sources at full cost. Failure to contact your Insurance Carrier for the above information may result in benefit denial, therefore, you will be responsible for payments in full.

I hereby certify that I have provided accurate and complete information concerning insurance or third party benefits as well as my eligibility thereof, and I agree to notify NCC of any changes relating thereto. I understand that my failure to notify NCC of any changes in my insurance benefits, false statements relating thereto, or failure to present Insurance/Medicaid cards monthly, will result in my being billed for the full and regular charges for services. I hereby agree to forward to NCC all insurance or third party payments received by me and further agree that my failure to do so will result in my being billed for the amount of all such payments. I understand that if I have Medicaid third party insurance, information I share with NCC employees may be released to my HMO provider. I understand that I have the right to file a grievance at any time services are denied, discontinued, suspended, or reduced. See #5 of Client Rights (reverse side).

I hereby agree to enter treatment with NCC. I understand that this application and anything else I tell the NCC personnel will be kept confidential with the exceptions listed in the client rights listed in the client rights statement (reverse side) which I understand. I hereby certify that the information stated on this form is correct to the best of my knowledge.

ASSIGNMENTS TO PAY BENEFITS: I hereby assign payment of any insurance benefits or third party payment benefits, otherwise payable to me, directly to NCC provided that such payments along with my fee for service shall not exceed the full and regular charges for services. This original or a copy of this agreement is to be equally accepted.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize NCC to release any and all information to my insurance company or other third party payment sources to enable NCC to obtain payment there from. This original copy of this Authorization is to be equally accepted. I have read the Client's Right Statement and Client Responsibilities Statement on the back of this form and understand my obligations regarding appointments and penalties for broken appointments. I agree to these conditions.

I have been given a copy of NCC's Notice of Privacy Practices. _____ (Initial)

Signature of Client_____Date_____

Signature of Responsible Party_____Date_____

Signature of NCC Staff_____Date_____

Northeastern Counseling Center

CLIENT'S RIGHTS STATEMENT

1. Be informed of your rights and responsibilities at the first interview.
2. Expect quality services.
    a. Regardless of the fee charged for the service.
    b. Regardless of the age, sex, ethnic origin or physical handicap.
3. Expect that any information, verbal or written, shared with the staff be kept confidential including your status as a client, the type of services you receive and the content of your discussions with your counselor. No information about you will be released without your written authorization except:
    a. In routine case consultations, conference and record audits involving the staff and other mental health professionals.
    b. When your records and/or the testimony of your courselor is subpoenaed by a court of law.
    c. When an emergency exists where there may be danger to yourself or others.
    d. When there is an incident of child abuse or neglect.
    e. When an anonymous form information may be shared for research purposes.
    f. When you are being referred to another agency within the Utah Mental Health System.

If you are being seen in conjunction with your spouse and/or family members, written authorization must be obtained from all adult members before any information will be released about the services provided. If only one member authorizes release of information, information will be abstracted from the record not pertaining to the individual authorizing release.

4. Participate in the formation of your goals for treatment and to periodic review of your goals for treatment and to periodic review of your treatment plan.
5. Discuss any dissatisfaction with the services received with another counselor, your counselor's supervisor, or the program director.
6. Be asked for written authorization before any interviews are audio or video taped.
7. Request to review with your counselor the information in your clinical record. Such requests must be submitted in writing to your counselor and the program supervisor. If such access is determined not to be in your best interest, you may authorize another health care professional to act in your behalf. (In case of minors 14 years or older, both the minor and the legal guardian are required to sign the request.)
8. Renegotiate your fees as your financial circumstances change.

CLIENT RESPONSIBILITIES

1. Protect the privacy of other clients if you are in group treatment. This includes not divulging information about the content of the group or in any way identifying the members of the group.
2. Arrive promptly for the scheduled appointments. If you are a parent/guardian and your child is in treatment, you are responsible to make the necessary arrangements for the child to come for the scheduled appointment. Failure to do so will result in being billed for the session.
3. Notify the receptionist (who will then notify your counselor) at least 24 hours in advance if you are unable to make a scheduled appointment, or it will be considered a broken appointment for which you will be billed. An emergency such as sickness, being called out to work, etc. would be an exception to this policy, but notifying Northeastern Counseling Center of these situations would be necessary to avoid being billed for the missed session.
4. Two or more broken appointments or a pattern of broken appointments will result in the termination of counseling services. The client could request services again, but would be considered a new client and would go back on the referral list and would need to complete the intake process. The client would then be assigned to appropriate services and may or may not be assigned to the same counselor.
5. If the client is terminated from counselling more than once for irresponsible behaviour in regards to keeping appointments, counseling services would be terminated and the client would not be eligible for regular counseling services for six months, with the exception of emergency situations.
6. Pay your fees at the time of service. If a third party payor is involved, you are also expected to promptly provide any necessary information (carrier, policy numbers, etc.) and forms.
7. Inform your counselor if there are any changes in your financial situation, address, or telephone number.
8. Discuss any dissatisfaction with your counselor concerning services received.

INFECTIOUS DISEASE SCREENING FORM

03/2017

Name: _____ Date: _____

The purpose of this form is to see if you should be tested for Tuberculosis, HIV or Hepatitis C.

TB disease in the lungs or throat can be infectious. This means that the bacteria can be spread to other people.

Have you been diagnosed with Tuberculosis TB at any time? Yes____ No____

Please indicate if you are having any of the following problems for three weeks or longer.

1.	Chronic Cough (greater than three weeks)	Yes____	No____
2.	Producing a lot of mucus and phlegm	Yes____	No____
3.	Blood-Streaked mucus and phlegm	Yes____	No____
4.	Unexplained weight loss	Yes____	No____
5.	Fever	Yes____	No____
6.	Fatigue/Tiredness	Yes____	No____
7.	Night Sweats	Yes____	No____
8.	Shortness of Breath	Yes____	No____

Would you like to receive TB testing? Yes_____ No____

Testing can be obtained at **The Tricounty Health Department** in Vernal or Roosevelt.

You may be at increased risk for HIV if you engage in unsafe sex or if you have ever used injection drugs.

You may be at increased risk for Hepatitis-C if you…

- Have ever injected illegal drugs (past or present), including Injecting only once many years ago
- If you have used illicit intranasal (snorted) drugs

HIV & Hepatitis C Testing can be accessed at the **Tricounty Health Department** in Vernal or Roosevelt. If you need assistance or would like to talk to someone about testing options, please let the receptionist know.

I would like to talk to someone about testing options

Yes _____ Not at this Time_____

CONFIDENTIALITY OF
ALCOHOL AND DRUG ABUSE PATIENT RECORDS

(Summary of Federal Drug and Alcohol Regulations, 42 CFR Part 2)

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by Federal laws and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser unless:

1) The patient consents in writing; OR

2) The disclosure is allowed by a Court Order; OR

3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation; OR

4) The patient commits or threatens to commit a crime either at the program or against any person who works for the program.

Violations of the Federal law and regulations by a program is a crime. Suspected violations may be reported to the United State Attorney in the district where the violation occurs.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

(See 42 U.S.C. § 290dd-22 for federal laws and 42 C.F.R. Part 2 for Federal Regulations.)

I have reviewed and understand the above stated information

Client Signature:_____ Date:_____

Employee Initials:_____ Date:_____