NORTHEASTERN COUNSELING CENTER
APPLICATION FOR SERVICE

07/2024

Clear Form

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:**		
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			
Total # of people in the home	**Total # of minor children in the home**			

PLEASE SELECT ONE ANSWER IN EACH SECTION BELOW

MARITAL STATUS:
- ☐ Married
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Never Married

RACE:
- ☐ Native American
- ☐ African American
- ☐ Alaskan Native (Aleut. Eskimo)
- ☐ Hawaiian/Pacific Islander
- ☐ Asian
- ☐ White/Caucasian
- ☐ Other single race
- ☐ Two or more races

ETHNICITY:
- ☐ Puerto Rican
- ☐ Mexican
- ☐ Cuban
- ☐ Other Hispanic
- ☐ Not Hispanic Origin

LIVING ARRANGEMENT:
- ☐ Homeless or Shelter
- ☐ Private Residence
- ☐ Private Residence with Supervision
- ☐ Jail or Correctional Institution or 24-Hour Residential
- ☐ Foster Care

PRESENTING PROBLEM(S):
- ☐ Depression/Anxiety
- ☐ Suicide Related
- ☐ Mental Health
- ☐ Substance/Alcohol Use
- ☐ IV Drug User
- ☐ DUI
- ☐ Other _____

REFERRAL SOURCE:
- ☐ Individual/Self
- ☐ Family or Friend
- ☐ School
- ☐ Employer/EAP
- ☐ DSPD
- ☐ Clergy
- ☐ DCFS
- ☐ Mental Health Provider
- ☐ Other Health Care Provider
- ☐ Alcohol/Drug Abuse Care Provider
- ☐ Division of Workforce Services
- ☐ Justice Referral or Court Order
- ☐ Other Community Referral

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

Vernal Office: vernalrecords@nccutah.org **Email the completed form here.** **Roosevelt Office:** rooseveltrecords@nccutah.org

OFFICE USE ONLY

Contact Date & Time:	**Eval Date & Time:**	**Eval Clinician:**	**Credible ID:**

☐ *MH Individual* ☐ *EOP and Individual* ☐ *SA Individual* ☐ *Medications* *Other:*	***Assigned to:***	***Clinicals Completed Date:***	***Initial:***

Northeastern Counseling Center

Fee Agreement

Client Information

July 2024

Last Name:	First Name:	Middle:

Responsible Party for Payment

Last Name:		First Name:	Middle
Address:			City:
State:	Zip:	Phone:	Birthday
Social Security Number (optional):		Relationship to Client:	

Sliding Fee Is Based on Family Size and Income Only:

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

Primary Insurance/Medicaid/Medicare

Insurance name:	Policy #:	Group #	
Address:	City:	State:	Zip:
Name of Insured:	Insured's Birthday		

Secondary Insurance/Medicaid/Medicare

Insurance name:	Policy #:	Group #	
Address:	City:	State:	Zip:
Name of Insured:	Insured's Birthday		

IMPORTANT: PLEASE READ BEFORE SIGNING

All clients are charged the actual cost for services rendered at Northeastern Counseling Center (hereafter NCC). Although you are responsible for services received, a discount may be available to you. NCC can offer this discount to you since Federal and State funds help operate NCC.

A reduced fee is offered to all clients and is based on family size and income only. Eligibility for a reduced fee is not dependent on other payment sources. In accordance with NCC's Sliding Fee Schedule, my fee has been set at $_____ per hour (minimum $5 charge). 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 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 and therefore you will be responsible for payments in full.

I hereby certify that the information stated on this form is correct to the best of my knowledge. 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 or Medicaid card will result in my being billed for the full and regular charges for services. I hereby agree to forward all insurance or third-party payments received by me to NCC 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 or third-party insurance, information I share with NCC employees may be released to my HMO provider.

I hereby agree to enter treatment with NCC. I understand that this application and anything else I tell NCC personnel will be kept confidential with the exceptions listed in the client rights statement on the reverse side, which I understand.

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 therefrom. This original copy of this Authorization is to be equally accepted. I have read the Client's Rights Statement and Client Responsibilities Statement on the back of this form and understand my obligations regarding 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

July 2024

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 age, sex, ethnic origin or physical handicap.
3. Expect that any information shared with the staff, verbal or written, be kept confidential including your status as a client, the type of services you receive and the content of your discussions with your counselor. 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 redacted from the record not pertaining to the individual authorizing the release.

    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 counselor 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.
4. Participate in the formulation of your treatment goals and to periodically review your goals and treatment plan.
5. Discuss any dissatisfaction with the services received with another counselor, your counselor's supervisor, or the program director.
6. File a grievance at any time services are denied, discontinued, suspended, or reduced.
7. File a complaint about a licensed provider. To do this, contact Division of Professional Licensing by phone at 801-530-6630 or email dopl@utah.gov.
8. Be asked for written authorization before any interviews are audio or video taped.
9. 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 certain cases of minors 14 years or older, both the minor and the legal guardian are required to sign the request.)
10. 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 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.
3. Notify receptionist (who will then notify your counselor) at least 24 hours in advance if you are unable to attend a scheduled appointment. Please be respectful of your therapist's time. If there is a pattern of broken appointments, alternative services will be discussed.
4. 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.
5. Notify receptionist or billing department if there are any changes in your financial situation, address, or telephone number.
6. Discuss any dissatisfaction with your counselor concerning services received.

Clear Form

INFECTIOUS DISEASE SCREENING FORM

10/2022

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

NORTHEASTERN COUNSELING CENTER
CONFIDENTIALITY OF
ALCOHOL AND DRUG ABUSE PATIENT RECORDS

Oct 2022

(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 by completing a Release of Information; 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 States 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 CFR Part 2 for Federal Regulations)

I have reviewed and understand the above stated information.

Client Signature:_____ Date:_____

Employee Initial and Date:_____