NORTHEASTERN COUNSELING CENTER
APPLICATION FOR SERVICE

Clear Form

01/2026

Vernal: vernalrecords@nccutah.org ⟵ **Email form to your preferred location.** ⟶ **Roosevelt:** rooseveltrecords@nccutah.org

Patient Name (First, Middle, Last)	**Gender** ☐ M ☐ F	**Age**	**Date of Birth**	**Social Security #**
Mailing Address (Address, City, State, Zip)	**Phone Numbers** **Home:** **Cell:**			
Physical Address (Address, City, State, Zip)	**County of Residence**		**Send text reminders to cell phone #?** ☐ Yes ☐ No	
Emergency Contact (Name, phone #, relationship to patient)	**Parent/Guardian, if a minor** (Name, Phone, Relationship to patient)			
Yrs of Education	**Have you enrolled/attended any education program in the last 3 months?** ☐ 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

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

May 2025

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. If you have questions or concerns about services you are receiving you may contact Department of Health and Human Services Division of Licensing directly at 801-538-4242 or email dlbc@utah.gov.
9. Be asked for written authorization before any interviews are audio or video taped.
10. 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.)
11. 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.

Youth Outcome Questionnaire Name: _____ ID: _____ Date: _____

Y-OQ®-30.2 English Youth Omni-Form

PURPOSE: The Y-OQ® 30.2 is designed to describe a wide range of troublesome situations, behaviors, and moods that are common to adolescents. You may discover that some of the items do not apply to your current situation. If so, please do not leave these items blank but mark the "Never or almost never" category. When you begin to complete the Y-OQ® 30.2 you will see that you can easily make yourself look as healthy or unhealthy as you wish. Please do not do that. If you are as accurate as possible it is more likely that you will be able to receive the help that you are seeking.

DIRECTIONS:

- Read each statement carefully.
- Decide how true this statement is during the **past 7 days.**
- Completely fill the circle that most accurately describes the past week.
- Fill in only one answer for each statement and erase unwanted marks clearly.

DIRECTIONS FOR PARENTS OR GUARDIANS:

If your child is under 12, the parent or other responsible adult is asked to complete this questionnaire. In this case, respond to the statements as if each began with "My child…" or "My child's…" rather than "I…" or My…." It is important that you answer as accurately as possible based on your personal observation and knowledge.

Please mark your answers like this:

Not like this:

Developed by:
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YOQ30ENG Version 1.0
1/05/2007

	Never or Almost Never	Rarely	Sometimes	Frequently	Almost Always or Always
1. I have headaches or feel dizzy.	○	○	○	○	○
2. I don't participate in activities that used to be fun……	○	○	○	○	○
3. I argue or speak rudely to others.	○	○	○	○	○
4. I have a hard time finishing my assignments or I do them …….. carelessly.	○	○	○	○	○
5. My emotions are strong and change quickly.	○	○	○	○	○
6. I have physical fights (hitting, kicking, biting, or scratching) ..…... with my family or others my age.	○	○	○	○	○
7. I worry and can't get thoughts out of my mind.	○	○	○	○	○
8. I steal or lie……...	○	○	○	○	○
9. I have a hard time sitting still (or I have too much energy).	○	○	○	○	○
10. I use alcohol or drugs……...	○	○	○	○	○
11. I am tense and easily startled (jumpy).	○	○	○	○	○
12. I am sad or unhappy…….	○	○	○	○	○
13. I have a hard time trusting friends, family members, or other adults.	○	○	○	○	○
14. I think that others are trying to hurt me even when they are not…..	○	○	○	○	○
15. I have threatened to, or have run away from home.	○	○	○	○	○
16. I physically fight with adults……	○	○	○	○	○
17. My stomach hurts or I feel sick more than others my same age.	○	○	○	○	○
18. I don't have friends or I don't keep friends very long…….	○	○	○	○	○
19. I think about suicide or feel I would be better off dead.	○	○	○	○	○
20. I have nightmares, trouble getting to sleep, oversleeping, or …….. waking up too early.	○	○	○	○	○
21. I complain about or question rules, expectations, or responsibilities.	○	○	○	○	○
22. I break rules, laws, or don't meet others' expectations on purpose.	○	○	○	○	○
23. I feel irritated.	○	○	○	○	○
24. I get angry enough to threaten others……...	○	○	○	○	○
25. I get into trouble when I'm bored.	○	○	○	○	○
26. I destroy property on purpose……...	○	○	○	○	○
27. I have a hard time concentrating, thinking clearly, or sticking to tasks.	○	○	○	○	○
28. I withdraw from my family and friends……...	○	○	○	○	○
29. I act without thinking and don't worry about what will happen.	○	○	○	○	○
30. I feel like I don't have any friends or that no one likes me….....	○	○	○	○	○

Clear All

Health Related Social Needs Screening

Client Name: _____ Date form Completed: _____

Purpose of the form: This optional form asks questions about your health-related social needs. The purpose is to see whether you would benefit from referrals or other services for health-related social needs.*

- ☐ *No thank you, I don't want to complete this form.*
- Please proceed if you are willing to complete this form.

1. What is your living situation today? [1]

- ☐ I have a steady place to live
- ☐ I have a place to live today, but I am worried about losing it in the future
- ☐ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, in a park, in a car, abandoned building, or other place unsuitable for people to live.)
- ☐ N/A - I was in a residential facility the last three months or longer (can include hospital, residential treatment, correctional facility, etc.)
- ☐ Uncomfortable in disclosing at this time

2. Within the past 3 months have you worried that food would run out for you and your family? [2]

- ☐ Often true
- ☐ Sometimes true
- ☐ Never true
- ☐ N/A - I was in a residential facility the last three months or longer (can include hospital, residential treatment, correctional facility, etc.)
- ☐ Uncomfortable in disclosing at this time

3. In the past 3 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living? [2]

- ☐ Yes
- ☐ No
- ☐ N/A - I was in a residential facility the last three months or longer (can include hospital, residential treatment, correctional facility, etc.)
- ☐ Uncomfortable in disclosing at this time

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*The One Albuque RQUE 2019 SDOH Screening Tool adapted questions were used as cited below.

[1] CMS AHC HRSN Q # 1. National Association of Community Health Centers and partners, National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, Association OPC, Institute for Alternative Futures. (2017). PRAPARE. http://www.nachc.org/research-and-data/prapare/

[2] Adapted from CMS AHC HRSN Q # 5. National Association of Community Health Centers and Partners, National Association of Community Health Centers, Association of Asian Pacific Community Health Organizations, Association OPC, Institute for Alternative Futures. (2017). PRAPARE. http://www.nachc.org/research-and-data/prapare/

4. **Has anyone, including family and friends, in the last 3 months, harmed you or threatened you with harm (physically, psychologically, or emotionally, which can include isolation, financial control, sexual abuse, or manipulation)?** [3]
   - ☐ Yes
   - ☐ No
   - ☐ Uncomfortable in disclosing at this time

5. **Do you want help finding or keeping work or a job or with school or training?** [4] **For example, finding a job, keeping a job, starting or completing job training or getting a high school diploma, GED or equivalent. Check all that apply.**
   - ☐ Yes, help finding work
   - ☐ Yes, help keeping work
   - ☐ Yes, help getting a high school diploma, GED or equivalent
   - ☐ Yes, help getting job training
   - ☐ I do not need or want help
   - ☐ Uncomfortable in disclosing at this time

6. **In the last 3 months has your use of substances interfered with your daily life?** [5] **(such as alcohol, non-medical use of drugs)**
   - ☐ Yes
   - ☐ No
   - ☐ Uncomfortable in disclosing at this time

7. **Has your mental health problems interfered with functioning in your daily life in the past 3 months?** [6] (For instance, feeling depressed, hopeless, disoriented, unmotivated, sleeping longer, crying uncontrollably, loss of appetite or weight loss) *If a client discloses suicidal ideation, the agency has the obligation to provide appropriate follow-up.
   - ☐ Yes
   - ☐ No
   - ☐ Uncomfortable in disclosing at this time

[3] Adapted from CMS AHC HRSN Q # 9. Sherin, K. M., Sinacore, J. M., Li, X. Q., Zitter, R. E., & Shakil, A. (1998). HITS: a Short Domestic Violence Screening Tool for Use in a Family Practice Setting. Family Medicine, 30(7), 508-512,

[4] Combined CMS questions # 12 and 16. Identifying and Recommending Screening Questions for the Accountable Health Communities Model (2016, July) Technical Expert Panel discussion conducted at the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Baltimore, MD.

[5] Combined and adapted CMS questions # 21 and 22. United States, U.S. Department of Health and Human Services, National Institutes of Health. (n.d.). Helping Patients Who Drink Too Much: A Clinician's Guide (2005 ed., pp. 1-34).

[6] Adapted from CMS question #23 a. and b. Kroenke, K., Spitzer, R. L., & Williams, J. B. (2003). The Patient Health Questionnaire-2: validity of a two-item depression screener. Medical Care, 41(11), 1284-1292.

8. **What prevents you from getting childcare for your children if you need it?** [7]
   - ☐ N/A (no children or do not need childcare)
   - ☐ Cannot afford childcare
   - ☐ Transportation
   - ☐ Do not know where to access childcare
   - ☐ Do not qualify for childcare
   - ☐ Uncomfortable in disclosing at this time

9. **In the past 3 months, have you used the emergency room instead of going to a primary care doctor or clinic due to lack of insurance or affordability?** [8]
   - ☐ Yes
   - ☐ No
   - ☐ N/A - I was in a residential facility the last three months or longer (can include hospital, residential treatment, correctional facility, etc.)
   - ☐ Uncomfortable in disclosing at this time

10. **In the past 3 months has the electric, gas, oil, or water company threatened or shut off services in your home?** [9]
    - ☐ Yes
    - ☐ No
    - ☐ N/A - I was in a residential facility the last three months or longer (can include hospital, residential treatment, correctional facility, etc.)
    - ☐ Uncomfortable in disclosing at this time

11. **How hard is it for you to pay for the very basics like food, housing, medical care, and heating?**
    - ☐ Often true
    - ☐ Sometimes true
    - ☐ Never true

❖ Please talk to your therapist about needs you may have.

[7]Adapted from *WellRx Toolkit,* University of New Mexico Office for Community Health

[8] Added by the City of Albuquerque, Department of Family and Community Services as an indicator of health needs.

[9] Adapted from CMS AHC HRSN Q # 6: Cook, J. T., Frank, D. A., Casey, P. H., Rose-Jacobs, R., Black, M. M., Chilton, M., Cutts, D. B. (2008). A Brief Indicator of Household Energy Security: Associations with Food Security, Child Health, and Child Development in US Infants and Toddlers. Pediatrics, 122(4), 867-875. doi:10.1542/peds.2008-0286