- Florie W. Jackson, LCSW
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www.saltlakecounselingservices.com

Intake Form

Please provide the following information and answer the questions below.
Please note: Information you provide here is protected as confidential information.

Save this form to your computer, then open with Adobe Acrobat and fill out on screen. Tab to move through the fields.

GENERAL INFORMATION

Today's Date: _____

Client's name: _____
(First) (Middle Initial) (Last)

Client's Date of Birth:_____ Age: _____ Gender: ☐ Male Female TG

Client's address: _____ ☐ ☐
(Street and Number)

_____
(City) (State) (Zip Code)

Social Security Number: _____

Home Phone: _____ May we leave a message? ☐ Yes ☐ No

Cell/Other Phone: _____ May we leave a message? ☐ Yes ☐ No
May we text? ☐ Yes ☐ No
E-mail Address: _____ May we email you? ☐ Yes ☐ No

Email and text correspondence are not considered to be a confidential medium of communication. Issues of a therapeutic nature will not be handled by text or email. Please initial to approve: _____

Emergency Contact Name: _____

Relationship to Contact: _____

Home Phone: _____ Cell Phone: _____

Who referred you or how did you find us? _____

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information, information entered into the computer, and written records about a client cannot be shared with another party without the written consent of the client. Noted exceptions are as follows:

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities.

In cases in which the client discloses or make reasonable implies a plan for suicide, the health care professional is required to notify legal authorities and attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing or has recently abused a child (or vulnerable adult) the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Service Information Disclosure, Clinicians Cell Phone, and Chance Public Encounters (when applicable)
Credit/debit card merchant services, third party payers, or billing companies are given information that they request regarding services to clients and the information is given to them via phone, fax, and unsecured email.

Information that may be requested includes, but is not limited to: check or credit card information, types of service, dates/times of service, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes and summaries.

The client's name, phone number and/or email will be entered into the clinician's personal cell phone in order to allow contact & record scheduled appointments. If the clinician's phone were lost, the client's name and contact information would be lost as well.
Is this OK with you? ☐ Yes ☐ No Initial_____

If the client were to see the mental health professional in public, the mental health professional would not disclose their relationship.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

_____ _____
Client s Name (print) Client's Signature

Date: _____

☐ Checking this box serves as your electronic signature.

CANCELLATION POLICY

If you are unable to make your scheduled appointment, we require you cancel at least 24 hours in advance so that another client can be scheduled at that time. If 24-hour notice is not given, you will be charged $120. If you fail to inform us at all and do not show for your appointment, you will be charged $120.

If you become ill, have unexpected car troubles, or are emotionally incapable of attending your appointment and 24-hour notice cannot be given, we understand that you cannot attend, nevertheless, the same rules apply simply due to the fact that the clinician could not schedule another client with such short notice.

By signing, you are agreeing to the terms listed above. Thank you for your consideration regarding this important matter.

_____ _____

Client s Name (print) Client's Signature

Date: _____ ☐ Checking this box serves as your electronic signature.

In order to insure payment for late cancel or no show appointments, it will be necessary that your personal credit or debit card be held on file in a secure location. This will be held in reserve in the event the cancellation policy is not observed.

By signing below, I agree, that Florie W. Jackson, LCSW may charge my credit card the amount of $120 if I don't show up for a scheduled appt. or cancel with less than 24 hours notice.

_____ _____

Client s Name (print) Client's Signature

Date: _____ ☐ Checking this box serves as your electronic signature.

(To be completed by Florie)

Na: _____

CCNu: _____

CCTy: _____ ExD:_____ Cd:_____

Adrs:_____

_____

PROFESSIONAL SERVICE AGREEMENT

Thank you for choosing SALT LAKE COUNSELING SERVICES. Our goal is to provide you with the best service possible so that you can receive hope and healing. We look forward to working with you to improve your life and your relationships. Please understand that due to factors beyond our control, such benefits and desired outcomes cannot be guaranteed.

In Case of Emergency

In addition, please be advised that SALT LAKE COUNSELING SERVICES does not provide 24-hour crisis services. In the event of an emotional, behavioral or medical crisis call the UUNI at 801 583 2500, call 911, or go to the ER.

Fees and Billing

Therapy sessions are 45-50 minutes each. The fee for an individual or couples' therapy session is $150.00. If you fail to arrive to the appointment on time, the session will still end at the allotted time and will be billed as a complete session.

Payment is due in full at the beginning of each session by cash, check, debit card or credit card. If payments are not made or attendance is unsatisfactory, Salt Lake Counseling Services reserves the right to deny service to any client.

If outstanding balance is not paid within 90 days of the last date of service, interest will be added at an annual percentage rate of 18%. If sent to collections, the client is responsible for any collection fees.

Requested returned phone calls of a therapeutic nature will be charged a service fee of $20.00 for every 15 minutes.

On the rare occasion that time is spent in responding to situations such as but not limited to: litigation, subpoenas, requests for information, personal injury lawsuits, attorney fees incurred by the clinician in your behalf, depositions, or court testimony the client will be charged $25 for every15 minute increment.

Letters or other paperwork requested by the client will be charged a $25.00 service fee.

The services provided by Salt Lake Counseling Services are not to deliver diagnostic evaluations of any kind for the purpose of but not limited to: child custody, legal disputes, public assistance, or determination of disability for the purposes of receiving SSI. The purpose of the services provided by Salt Lake Counseling Services is "talk therapy" only. Salt Lake Counseling Services reserves the right to deny service to any client.

There will be a $25 fee for any cancelled check.

I HAVE READ, UNDERSTAND AND AGREE TO THE INFORMATION AND POLICIES AS STATED ABOVE, AND I GIVE CONSENT FOR TREATMENT AT SALT LAKE COUNSELING SERVICES.

_____ _____

Client s Name (print) Client's Signature

Date: _____

☐ Checking this box serves as your electronic signature.

Patient Privacy Policy (H.I.P.P.A.)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

1. **Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.**
2. **We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.**
3. **HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU**
   a. **For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.**
   b. **For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.**
   c. **For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.**
   d. **Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.**
   e. **Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.**
4. **As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.**
   a. **Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.**
   b. **Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.**
   c. **Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.**
   d. **Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.**
   e. **Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.**
   f. **Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.**
   g. **Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.**
   h. **Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.**
   i. **Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.**
   j. **Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.**
   k. **Research. PHI may only be disclosed after a special approval process or with your authorization.**

l. Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

m. Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

n. With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of progress notes. In rare occasions, psychotherapy notes, if psychotherapy notes are created by the clinician, which are separated from the rest of your medical record.; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

5. YOUR RIGHTS REGARDING YOUR PHI

a. You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to Florie W. Jackson at Salt Lake Counseling Services.

b. Right of Access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. This right applies to medical and billing records, but does not apply to psychotherapy notes or information gathered or prepared for a civil, criminal, or administrative proceeding. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

c. Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.

d. Right to an Accounting of Disclosures. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

e. Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

f. Right to Request Confidential Communication. You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.

g. Breach Notification. If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

h. Right to a Copy of this Notice. You have the right to a copy of this notice.

6. COMPLAINTS: If you believe we have violated your privacy rights, you have the right to file a complaint in writing to Florie W. Jackson at Salt Lake Counseling Services or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. We will not retaliate against you for filing a complaint.

I have read and understand this privacy notice, and I understand my rights concerning the use and disclosure of protected healthcare information.

Would you like a copy of the Patient Privacy Policy (H.I.P.P.A.)? ☐ Yes ☐ No

_____

Client's Name (print)

Client's Signature

Date: _____

☐ Checking this box serves as your electronic signature.

SYMPTOM CHECKLIST Name:_____

Check the box that most accurately describes how much you have experienced each symptom over the past 6 months

SYMPTOM	NOT AT ALL	SOMETIMES	FREQUENTLY	MOST OF THE TIME
Difficulty sustaining attention, easily distracted	○	○	○	○
Makes careless mistakes	○	○	○	○
Trouble listening	○	○	○	○
Trouble following through with tasks	○	○	○	○
Often loses necessary items (i.e. keys, etc.)	○	○	○	○
Forgetful in daily activities	○	○	○	○
Fidgety, trouble holding still	○	○	○	○
Talks excessively, Blurts out answers	○	○	○	○
Difficulty awaiting your turn	○	○	○	○
Feeling sad or empty most of the day, nearly everyday	○	○	○	○
Diminished interest in activities that used to interest you.	○	○	○	○
Either excessive weight gain/loss or increased/decreased appetite	○	○	○	○
Trouble with sleep (either too much or too little)	○	○	○	○
Fatigue-tired all the time	○	○	○	○
Feelings of worthlessness, low self-esteem, or guilt	○	○	○	○
Thoughts of suicide	○	○	○	○
Worry excessively	○	○	○	○
Irritability	○	○	○	○
Muscle Tension	○	○	○	○
Persistent fear of one or more social situation in which you are exposed to new people or possible scrutiny	○	○	○	○
Fear of being in places or situations from which escape might be difficult or embarrassing and help might not be available	○	○	○	○
Refusal to maintain "normal" body weight	○	○	○	○
Extreme fear of gaining weight	○	○	○	○
Binge Eating	○	○	○	○
Throwing up food after binging	○	○	○	○
Compensatory behavior in order to prevent weight gain (i.e. over exercising, using laxatives, etc.)	○	○	○	○

Continue on 2nd page

SYMPTOM	NOT AT ALL	SOMETIMES	FREQUENTLY	MOST OF THE TIME
Do you experience "episodes" (3 days to several months) of the symptoms below: • Inflated self-esteem/grandiosity	○	○	○	○
• Decreased need for sleep (3 hours)	○	○	○	○
• Racing thoughts	○	○	○	○
• Goal oriented or restless behavior (i.e. deep cleaning the house top to bottom, etc.)	○	○	○	○
• Extremely talkative	○	○	○	○
• Involvement in activities that have high potential for painful consequences (i.e. gambling, sex, etc.)	○	○	○	○
Do you experience 'episodes' of panic (1-10 minutes) of the symptoms below: • Heart palpitations	○	○	○	○
• Sweating	○	○	○	○
• Trembling or shaking	○	○	○	○
• Shortness of breath	○	○	○	○
• Feeling of choking	○	○	○	○
• Chest pain	○	○	○	○
• Nausea	○	○	○	○
• Feeling detached from oneself	○	○	○	○
• Fear of losing control	○	○	○	○
• Fear of dying	○	○	○	○
• Numbness or tingling sensation	○	○	○	○
• Chills or hot flashes	○	○	○	○
Have you ever experienced an event that involved the threat of death or serious injury to yourself or others or was extremely traumatic? (Witness a murder or suicide, car accident, physical or sexual abuse, domestic violence, etc.)		☐ Yes	☐ No	
Have you had nightmares or flashbacks about these events recently?		☐ Yes	☐ No	

Email form as an attachment to fjax.lcsw@gmail.com.
Alternately, you can print, sign, and bring to your appointment.