**A black and white compass

AI-generated content may be incorrect.**

**Client Application for Admission**

*Important notice: this application contains confidential and privileged health information that is protected from misuse and unauthorized disclosure by the health insurance portability and accountability act of 1996.  The information contained in this application is intended only for the use by this agency and shall not be released without the prior written consent of the individuals involved. St Anthony House Treatment Programs, LLC is the corporation that supports services provided by our affiliates, The Utah House, Sagamore Counseling, Texas Family Support, Sagamore NY, and LifeView.*

**Client Name (legal name):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_\_\_\_\_ **Age**:\_\_\_\_\_\_\_\_

Preferred name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred pro-nouns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Insurance Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Member ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have secondary insurance: \_\_\_\_\_ NO**

**\_\_\_\_ Yes, Name of the insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary address of client**

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Town/City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ zip code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do we have permission to text you: \_\_\_\_Yes \_\_\_No

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do we have permission to email you: \_\_\_\_ Yes \_\_\_ No

Will you be needing transportation: \_\_\_\_\_ YES \_\_\_\_ NO

**Responsible Party if under 18** *\_\_\_\_\_\_\_\_\_ NA. I am over 18.*

Parent/Guardian’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email of responsible party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact (information will not be shared without a signed consent on file):**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you give permission for your emergency contact to be notified in the event you might be of harm to yourself or others? □ Yes □ No

**Marital Status**:

□ Married □ Never Married □ Divorced □ Domestic Partner □ Legally Separated □ Widowed

**Race/Ethnicity** □ Hispanic □ non-Hispanic

*Please check the box that best represents your race/ethnic background: (optional)*

□ American Indian or Alaska native □ Asian □ Black or African American

□ Native Hawaiian or Other Pacific Islander □ Two or more races □ White □ Refuse to Answer

**Sexual Orientation** (Optional)

□ Heterosexual □ Homosexual □ Bisexual □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Refuse to Answer

**Education:** Highest (or current) Grade Level Achieved: \_\_\_\_\_\_\_\_\_\_\_ Current school \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current/Past Military History**

Are you currently serving or have you served in the military? □ Yes □ No

**ADA ACCOMEDTIONS NEEDED**: NO\_\_\_\_WHEELCHAIR \_\_\_ HEARING AIDS\_\_\_ OTHER: \_\_\_\_\_\_

**Primary Health Care Provider**

Provider/Practice Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical History** None \_\_\_\_\_

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Height\_\_\_\_\_\_\_\_\_ Current Weight\_\_\_\_\_\_\_\_\_\_

Significant Past Medical History: □Yes □No

If *yes, explain:*

**Medical History (check any that apply)**

|  |  |  |
| --- | --- | --- |
| □ Head Injury/Concussion  □ Stroke  □ Loss of Consciousness  □ Seizures  □ Sleep Disturbances  □ Appetite Changes  □ Parasites/Scabies/Lice | □ Thyroid Problems/Disease  □ Heart/Vascular Problems/Disease  □ Respiratory Problems  □ Kidney Problems/Disease  □ Liver Problems/Disease  □ Diabetes  □ Hypertension | □ Cancer  □ Allergies  □ STD  □ Weight Changes  □ Chronic Pain \_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Currently Pregnant |

Please list any current **non-psychotropic** medications and supplements you are taking:

|  |  |  |
| --- | --- | --- |
| **Name of Medication** | **Dosage/Amount** | **Frequency** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Mental/Behavioral Health Treatment History** None□

Have you ever been inpatient or hospitalized for mental health services? □ Yes □ No

When was your most recent stay? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last Assessment\_\_\_\_\_\_\_\_\_\_\_\_ Assessors Name/Agency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ None□

**Current or previous Mental/Behavioral Health Provider** None□

Provider Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Practice Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Mental Health Diagnosis DX: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication Management**

Looking for Medication prescribed through our agency? (Mass Only): □ Yes □ No

Currently on meds: □ Yes □ No

**Psychiatric Medication Prescriber:** None□

Provider/Practice Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any current **psychotropic** medications you are taking:

|  |  |  |
| --- | --- | --- |
| **Name of Medication** | **Dosage/Amount** | **Frequency** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Have you had an allergic reaction to medication(s)? □ Yes □ No

Preferred Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Substance Use**

Do you drink alcohol? □ Daily use □ Occasional Use □ None

Do you use tobacco? □ Daily use □ Occasional Use □ None

Do you use drugs? □ Daily use □ Occasional Use □ None

Has alcohol/drug use interfered with family, work, health, or interpersonal life? □ Yes □ No

Have others viewed your use as a problem? □ Yes □ No

Have you ever tried to cut down on your alcohol or drug use or quit using? □ Yes □ No

Have you had any prior substance abuse treatment? □ Yes □ No

When? Where?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Legal History**

Involved with Child Protective Services or have a DCF worker? □ Yes □ No

Do you currently have a case worker, probation or parole officer? □ Yes □ No

If yes, name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you currently court involved?**  □ Yes □ No

**Spiritual** What is your present religious affiliation, if any? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In your experience, how important are spiritual matters? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any cultural affiliations staff should be aware of/sensitive to? □ Yes □ No

Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***By signing, I, agree to not hold Saint Anthony House Treatment Programs, LLC; or The Utah House, Sagamore Counseling, Texas Family Support; or any other entity associated with the organization liable for any injury, mental or physical when engaging service; either on or off property. I understand my rights and risks as a client and/or guardian of a client seeking services with this agency.***

***By signing this agreement, you understand the risks and responsibilities of doing therapy as well as the therapy services provided by telehealth. In addition, you understand the agency’s billing and privacy practices and give permission to the agency to provide services to myself and/or my child as well as my HIPPA and the agency’s privacy practices.***

***Please see the forms below. Additional forms, program manuals including rules and expectations, client rights, how to file a complaint, more information on our privacy practices and our insurance handbooks can be found on the website www.theuthouse.com.***

Client/Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_

**Consent For Credit Card/Financial Agreement**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_am the patient or responsible party. I understand my health plan may not pay for or cover the services provided by this agency. I understand it is my responsibility to contact the insurance plan to know my out-of-pocket costs. I understand the agency will bill the insurance’s fee schedule and any amount due is based on the insurance’s pre-determined set fee schedule and co-payments/coinsurances and deductibles are set by the insurance plan. In addition, I understand I am responsible for any missed appointment fee of $50.00 per missed session. I agree to allow the agency to keep my credit card information and charge my card for missed sessions, copayment, coinsurance and deductibles if any. Services may need to be suspended if I am unable to pay my balance in full or make financial arrangements with the agency. A 5% interest rate will apply to balances over 30 days and I understand I will be sent to collects for failure to pay after 90 days.

Name on Credit Card: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Card number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exp date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Security Code \_\_\_\_\_\_\_\_\_\_\_ Zip Code of card \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If you are uncomfortable providing a card number on this application, please contact our office and we will get the information, and it will be kept in our secure system. Failure to provide a card may prevent or delay services. Again, please contact the office with any questions or concerns.*

**Consent for Enrollment/Privacy Practices**

**\_\_\_\_\_ (initial) Permission to Treat & Assess** Saint Anthony House Treatment Programs, LLC (the “agency”) is the corporate parent of Sagamore Counseling, Utah House and Texas Family Support and Lifeview Therapies. I hereby authorize the agency to provide mental health treatment and services, including but not limited to, individual therapy, family therapy, group therapy, psychological assessments, and any other therapeutic interventions deemed necessary by the treatment team. This authorization includes mental health services aimed at improving emotional, psychological, and behavioral well-being, and may also encompass case management, crisis intervention, medication management, and supportive counseling as required.

I understand that my treatment plan will be tailored to address my specific mental health needs and may include services addressing both behavioral management and broader mental health concerns. In cases where behavior management services are necessary, they may be provided by a non-licensed associate under the supervision of a licensed therapist.

I further understand that all sessions and information shared during treatment are confidential, except in circumstances where there is a risk of harm to myself or others, or as otherwise required by law. I also understand information about my sessions may be shared with my insurance provider or primary payor. I understand my Medicaid/Medicare client rights (if applicable) and understand my insurance costs/rights and responsibilities.

I understand that I have the right to any documentation provided to my insurance regarding myself, family and/or child. I understand that I am financially responsible for any services performed by the agency that are not covered by my insurance and cannot be billed for services covered by Medicare/Medicaid if my coverage is active. I agree to pay for the services performed and agree to inform the agency of any changes to my insurance coverage. I also agree and understand that it is my responsibility to keep my insurance coverage current and inform the agency of any changes.

This authorization will remain in effect until such time as it is revoked in writing or until treatment is concluded.

**\_\_\_\_\_ (initial) Receipt of Privacy Practices** The agency must collect timely and accurate health information about you and make that information available to members of your health care team in this agency, so that they can accurately diagnose your condition and provide the care you need. There may also be times when your health information will be sent to service providers outside this agency for services that this agency cannot provide.

It is the legal duty of the agency to protect your health information from unauthorized use or disclosure while providing health care, obtaining payment for that health care and for other services relating to your health care. The purpose of the *Notice of Privacy Practices* is to inform you about how your health information may be used within *this agency* as well as reasons why your health information could be sent to other service providers outside of this agency. If you have any concerns about your confidential information, please contact the director, Alycia Jurgela at 801-678-3317. If at any time you want your information shared, please request a release of information and the information will be shared with your consent only to those you wish to have the information.

If while in sessions, groups or at a program, you see or hear information regarding a fellow participant, we ask that you respect the confidentiality of that information.

I have understood the *Notice of Privacy Practices*, which describes this agency’s methods for protecting the privacy of my health information that is used in providing health care services to me.

**\_\_\_\_\_ (initial) Consent For Telehealth**

**\_\_\_\_\_ (initial) I do not give consent for Telehealth**

Telehealth is a way to visit healthcare providers, such as your therapist, behavioral manager or nurse practitioner. We use telehealth as an option for those who cannot come to the office for any reason, such as bad weather, illness or for convenience. You can talk to your provider from any place, including your home. If people are close to you, they may hear something you did not want them to know.

Some things to know:

* You should be in a private place, so other people cannot hear you.
* You talk to your provider by phone, computer, or tablet. A link will be sent to you in a calendar invite or by text.
* You and your provider won’t be in the same room, so it may feel different than an office visit.
* Your provider may decide you still need an office visit.
* Technical problems may interrupt or stop your visit before you are done.
* We will not record visits with your provider.
* Your provider will tell you if someone else from their office can hear or see you.
* We use telehealth technology that is designed to protect your privacy.
* If you use the Internet for telehealth, use a network that is private and secure.

**What if I try telehealth and don’t like it?**

* You can stop using telehealth any time, even during a telehealth visit.
* You can still get an office visit if you no longer want a telehealth visit
* If you decide you do not want to use telehealth again: call or text 801-678-3317 and say you want to stop, it will be as if you never signed this form.