Intake

Potential Client Information

Name (last, first, middle):_____

Address (Street, City, State, Zip)_____

Date of Birth:_____

Gender: Male ☐ Female ☐

Social Security Number:_____

Emergency Contact Name:_____

Emergency Contact Phone:_____

Best Phone Number:_____

Is It Okay to Call: Yes ☐ No ☐

Type of Appointment Reminder: Text ☐ Email ☐ Both ☐ Phone call ☐

Appointment Reminder Email Address:_____

Appointment Reminder Cell Phone:_____

Family Size:_____

Number of Dependent Children at Home Under 17:_____

Are you Pregnant: Yes ☐ No ☐

Demographics

Referral Source:

☐ Juvenile Court
☐ Private Practice Professional
☐ School System
☐ Social/Community Agency
☐ Other:
☐ Family/Friend
☐ District Circuit Court
☐ Physician/Medical Facility
☐ Other Mental Health Center
☐ Self
☐ Nursing Home
☐ Clergy
☐ Law Enforcement Correctional
☐ Public Psychiatric Hospital

Employment:

☐ Age 0-5
☐ Employed Part-Time -35 hours
☐ Retired
☐ Unemployed Seeking
☐ Disabled, Not Working
☐ Unemployed/not seeking
☐ Student
☐ Employed Full-Time 35 hours+
☐ Homemaker
☐ Supported/transitional employment

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Yes ⬓ No ⬓ Are you interested in employment or education assistance

Yes ▣ No ⬓ Would you like us to help you with employment/education

Marital Status:

⬓ Married ⬓ Divorced ⬓ Separated
⬓ Widowed ⬓ Never married/single ⬓ Domestic partner/unmarried

Race [primary]:

⬓ White ⬓ Alaskan native ⬓ Pacific Islander ⬓ American Indian/Native American
⬓ Asian ⬓ Black/African America ⬓ Other: _____

Ethnicity [primary]:

⬓ Cuban ⬓ Mexican ⬓ Puerto Rican ⬓ Not of Hispanic origin
⬓ Other: _____

Language (if other than English): _____

Living Arrangement:

⬓ 24 hour Residential ⬓ Foster Home (Adult or Child) ⬓ Institutional Setting
⬓ Jail ⬓ Homeless or Shelter ⬓ Private Residence-Dependent
⬓ Private Residence-Independent

Have you ever or are you currently serving in the military? ☐ Yes ☐ No ⬓ Unknown

Enrolled in Education in the Last 3 Month: Yes ⬓ No ⬓
Years of Education Completed:_____
Have You Previously Had Mental Health Treatment: Yes ⬓ No ⬓
Have You Even Been Hospitalized at the Utah State Hospital: Yes ⬓ No ⬓
Have You Even Been Treated at Davis Behavioral Health: Yes ⬓ No ⬓

Have You Ever Taken Any of the Following Medications: (Clozaril, Seroquel, Zyprexa, Risperdal, Geodon)
Yes ⬓ No ⬓

A Codependent client Is someone seeking services because of problems arising from his/her relationship with an alcohol or drug abuser. Has been formally admitted for service to a program. Has his/her own client record. Yes: ⬓ No: ☐

Number of Arrests in the Past 30 Days:_____

SUD ONLY—Days Waiting To Enter Treatment:_____

Compelled to Treatment (Court Involved): Yes ⬓ No ⬓

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Tobacco Use:

- ☐ Never Smoked/Vaped
- ☐ Former Smoker/Vape
- ☐ Current Someday Smoker
- ☐ Current Everyday Smoker
- ☐ Use Smokeless Tobacco

Age of First Use:_____

Billing/Income

Billing First Name:_____

Billing Last Name:_____

Billing Address (Street, City, State, Zip):_____

Billing Phone:_____

Billing Income:_____

MH Expected Payment Source:

- ☐ Champus
- ☐ Commercial Insurance
- ☐ Medicaid
- ☐ Medicare
- ☐ Other Private Resources
- ☐ Other Public Resources
- ☐ Personal Resources
- ☐ Provider to Pay Most Costs
- ☐ Service Contract
- ☐ Veterans Administration
- ☐ Workers Compensation

SUD Expected Payment Source:

- ☐ Blue Cross
- ☐ Chip
- ☐ Drug Court
- ☐ Medicaid
- ☐ Medicare
- ☐ No Charge
- ☐ Other
- ☐ Other Gov Resources
- ☐ Other Health Insurance
- ☐ Self Pay
- ☐ Workers Compensation

Primary Income Source:

- ☐ Disability, Workers Compensation
- ☐ Legal Employment, Wages, Salary
- ☐ None
- ☐ Other
- ☐ Pension, Retirement, Social Security
- ☐ Welfare, Public Assistance

Is This Client Uninsured (Self Pay): Yes ☐ No ☐
IF YES COMPLETE THE FINANCIAL INFORMATION BELOW.

Earnings/Wages: _____

Workers Compensation:_____

SSI: _____

SSD: _____

Intake

Social Security: _____

Retirement _____

Food Stamps: _____

Welfare Benefits: _____

Alimony/Child: _____

Other Income: _____

Total Monthly Income $ _____

Therapy Copay $: _____

Medical Copay $: _____

Intake

Consent and Privacy Rights

☐ CO-PAY: It is my responsibility to pay my co-pay at the time of each session. Should my private insurance pay me directly, I understand I will be billed the full cost of service.

☐ Cancellation and No Shows: I understand that I may be charged a $25 no-show fee for missed appointments, or if I fail to cancel my appointment within 24 hours.

☐ Insurance: I understand that changes in monthly income and insurance coverage may occur and that my co-payment may change as a result. I will notify Davis Behavioral Health of any changes immediately.

☐ Billing Information: I agree that my family member, guardian, or person acting on my behalf may talk with DBH about my billing information and other billing matters related to my treatment at DBH.

☐ Collections: If for any reason your account has not been paid in full at discharge, an 18% collection fee will be added, and the account will be turned over to collections.

☐ Privacy and Clients Rights: I have been made aware that the DBH Notice of Privacy Practices and Client Rights Statement can be found on the DBH Website.

☐ Advance Directives: I have been provided with information regarding Advance Directives and know that I may ask a therapist about any questions I may have.

☐ Yes ☐ No I currently have Advance Directives and a copy has been provided to DBH.

☐ Yes ☐ No Medicaid Transportation: I am aware of how to access alternative methods of transportation (for clients enrolled in the Prepaid Mental Health Plan.

☐ Yes ☐ No Grievance/Appeals: I am aware of how to access Davis Behavioral Health's grievance and appeals process.

☐ Yes ☐ No I give permission to Davis Behavioral Health to treat me for my behavioral health problems.

☐ Jail Evaluation, if Applicable, can be found in jail record.

☐ Yes ☐ No I agree to let DBH share my medical records with my other medical providers through the Health Information Exchange HIE.

☐ Telehealth is the delivery of behavioral health services using interactive technologies (audio, video and/or other electronic communications) between me and my healthcare provider who are not in the same physical location.

☐ During the provision of Telehealth services, my healthcare provider and I shall freely communicate my personal health information.

☐ DBH will implement network and software security protocols to protect the privacy of my personal health information. However, **I acknowledge and accept the inherent risk of utilizing technology for the delivery of Telehealth services.** Such risks may include, but are not limited to, breaches of confidentiality, theft of personal information, disruption of service, etc.

☐ I have fully considered the benefits and risks of participating in Telehealth and have had the opportunity to ask questions of DBH staff. **I consent to participation in Telehealth services from DBH by one or more of the following methods: 1) signing this form electronically, 2) signing and mailing a hard copy, OR 3) (if one of the previous two methods is not feasible such as during the COVID-19 outbreak), by connecting with my healthcare provider via technology at which time the provider will note my verbal consent.**

Signature: _____ Date: _____