Fremont
COUNSELING SERVICE
Quality. Service. Progress. Recovery. Since 1959.

LANDER OFFICE
748 Main Street, Lander, WY 82520
Phone (307) 332-2231 • Fax (307) 332-9338

RIVERTON OFFICE
1110 Major Avenue, Riverton, WY 82501
Phone (307) 856-6587 • Fax (307) 856-2668

TTY HEARING IMPAIRED
1 (800) 877-9975

Appointments can be conducted via Zoom or in-person

All Intake Paperwork needs to be turned in via paper or email before your Intake appointment can be scheduled. You will also need to bring the following information with you to this appointment or turn it in in advance:

1. ☐ Photo identification.

2. To determine eligibility for a discounted fee, please provide proof of household income.
   a. ☐ This can include: most recent pay stub, most recent tax return, bank statement noting deposit of regular income, Social Security benefits statement.
   b. ☐ If an individual is unemployed, they must complete and submit a Statement of Support form.

3. ☐ Insurance cards: Medicaid, Medicare, or other third party/insurance payer.
   a. If you are covered under another person's insurance, please bring their insurance card.

4. ☐ If you are Court Ordered to be here, you MUST provide us with a copy of the Court Order, Bond Order, or Change of Plea Order when you turn in your intake paperwork.

5. ☐ List of medications that you take on a regular basis (including dosage and frequency):
   a. This can include vitamins and/or other supplements, over-the-counter and/or prescription medications.

6. If the appointment is for a **<u>minor child</u>**:
   a. ☐ A parent or legal guardian must be present for the entire intake to sign necessary paperwork and the Consent for Treatment and to participate as needed in the interview.
   b. ☐ A legal guardian must bring in proof of custody/guardianship in order to sign consents for treatment. (This does not apply to the minor child's parent.)
   c. ☐ If a child's parents are divorced, please have a copy of the divorce decree specifying who has custody and may consent to the child's treatment.

7. If you need an ASI (Addiction Severity Index) and/or substance use evaluation:
   a. ☐ The ASI is done via computer and may be done at any time during business hours from 8 AM to 4 PM, or we can email you a link to complete the evaluation from your home computer. **This costs $25 which must be paid before you can begin.**
   b. ☐ The interview is then conducted during a scheduled appointment.
   If you had an ASI/ASAM in the previous 3 months, bring the final report with you. If you do not bring the ASI/ASAM, you may be asked to return another time or you may complete one here via computer for $25.

We look forward to serving you. If you have any questions, please feel free to give us a call!

FREMONT COUNSELING SERVICE

Client information Form – please respond to all questions.

Client's Last Name | **Client's First Name** | **Middle Initial**

Do you have a twin? ☐Yes ☐ No

Preferred Name | **Maiden Name / Other Names or Aliases**

Mailing Address (Address 1) | **City** | **State** | **ZIP**

Physical Address (Contact Details: Address 2) | **City** | **State** | **ZIP**

Telephone Number ☐ Mobile ☐ Home ☐ Work ☐ Voice message OK ☐ Text message OK

Remind me of my appointments by: ☐Email ☐Phone Call / Voice Mail ☐ Mobile Text ☐ Patient Portal

Email Address (**Email address is required to access the Patient Portal.**)

Social Security Number (***REQUIRED!***) | **Date of Birth**

Biological Gender: ☐ Male ☐ Female ☐ Unknown/Other

Gender Identity:
☐ 1.Cisgender Male ☐ 2.Cisgender Female ☐ 3.Trans Man/FTM ☐ 4.Trans Woman/MTF
☐ 5.Genderqueer/Gender Non-conforming ☐ 6.Additional Gender Category/Other ☐ 9.Unknown/Prefer not to disclose

Sexual Orientation:
☐ 1.Straight/Heterosexual ☐ 2.Lesbian/Gay ☐ 3.Bisexual ☐ 5.Other ☐ 6.Queer ☐ 7.Pansexual ☐ 8.Questioning
☐ 9.Unknown/Prefer not to Disclose ☐ 10.Asexual

Marital Status:
☐ 1.Never Married ☐ 2.Now Married ☐ 3.Spouse Absent ☐ 4.Divorced ☐ 5.Widowed ☐ 6.Minor Child ☐ 7.Unknown

Race:
☐ 1.White ☐ 2.Black ☐ 3.Native American/Alaskan ☐ 4.Asian ☐ 5.Other/Unknown ☐ 6.Native Hawaiian

Hispanic Origin:
☐ 2.Not Hispanic ☐ 3.Cuban ☐ 4.Puerto Rican ☐ 5.Mexican ☐ 6.Other Hispanic ☐ 7.Unknown

Employment Status:
☐ 1.Unemployed ☐ 2.Employed PT (less than 30 hrs/wk) ☐ 3.Employed FT (more than 30 hrs/wk) ☐ 4.Homemaker
☐ 5.Retired ☐ 6.Disabled (Unemployed) ☐ 7.Child (0-15 yrs) ☐ 8.Student (16+ yrs) ☐ 9.Inmate ☐ 12.Volunteer

Residential Status:
☐ 1.Homeless ☐ 2.Private Residence / Household ☐ 3.Group Home ☐ 4.Residential/Inpatient ☐ 5.Foster Home
☐ 6.Jail ☐ 7.Hospital ☐ 8.Other Residential Setting ☐ 9.Unknown ☐ 10.Nursing Home

Primary Language: ☐ English ☐ Spanish ☐ Sign Language ☐ Other: _____
Will you require translation services? ☐ Yes ☐ No

Veteran Status: ☐ 1.Veteran (non-combat) ☐ 2.Not a veteran ☐ 3.Veteran (combat)

Last Grade of School Completed: _____
☐ No schooling (0) ☐ Kindergarten/1st Gr (1) ☐ Diploma/GED (12) ☐ 1 yr college (13) ☐ 2 yrs college/AAS (14)
☐ 3 yrs college (15) ☐ Bachelors (16) ☐ Masters (18) ☐ Doctorate (20) ☐ Unknown (99)

FREMONT COUNSELING SERVICE

Who referred you to us?

☐ 1.Self	☐ 2.Family / Friends	☐ 3.Law Enforcement	☐ 4.Court
☐ 5.Private Psychiatrist	☐ 6.Other MD	☐ 7.Other Private MH Provider	☐ 8.Clergy
☐ 9. WY State Hospital	☐ 10.Other Inpatient Psychiatric Treatment		☐ 11.Drug / Alcohol Treatment
☐ 13.Shelter	☐ 14.Behavioral Health Center		☐ 15.Other
☐ 16.School	☐ 17.Employer	☐ 18.DFS	☐ 19.DVR
☐ 20.Nursing Home	☐ 21.Medical Hospital	☐ 22.DD / CES	☐ 23.Drug Court
☐ 25.Adult Probation/Parole	☐ 26.Juvenile Probation/DFS	☐ 27.CDS/Head Start	☐ 28.Attorney
☐ 29.Veterans Affairs	☐ 30.Dept of Corrections	☐ 32.SS / Disability	☐ 33.WLRC
☐ 34. #988	☐ 35.Youth Crisis Center	☐ 36.WBI	☐ 99.Unknown

Primary Income Source:

☐ 1.Self	☐ 2.Family (Parent/Guardian/Spouse/Adult Children		☐ 3.SSI (Supplemental Security Income)
☐ 4.SSDI (Social Security Disability Income)	☐ 5.Other Disability Income	☐ 6.Retirement Income	
☐ 7.DFS / Welfare Assistance	☐ 8.Unemployment	☐ 8.Other	☐ 99.Unknown

PERSON RESPONSIBLE FOR PAYMENT OF SERVICES

Responsible Person's Name _____ Social Security Number _____ Date of Birth _____

Address _____ City / State / ZIP _____ Phone Number _____ Relationship to Client _____

Insurance Company _____ Policy/Group ID Number _____ Copay Amount _____

Medicaid/CHIP Number _____

Please present your insurance card to the front desk at check in. ☐ **No Insurance**

EMERGENCY CONTACT

Name _____ **Address / City / State / ZIP** _____ **Phone Number** _____

Relationship:

☐Spouse /Domestic Partner ☐Sibling ☐ Parent /Foster Parent /Grandparent ☐Child ☐Friend ☐Guardian /Legal Representative ☐Other

LEGAL STATUS ☐ Adult, no Guardian ☐ Adult, has Guardian ☐ Minor, has Guardian ☐ Minor, Emancipated

Guardian's Name _____ **Address / City / State / ZIP** _____ **Phone Number** _____

Relationship:

☐Spouse /Domestic Partner ☐Sibling ☐ Parent /Foster Parent /Grandparent ☐Child ☐Friend ☐Guardian /Legal Representative ☐Other

Printed Name of Person Completing Form _____ Date _____

Signature of Person Completing Form _____ Phone Number _____

FREMONT COUNSELING SERVICE
Intake Form

Name Age Date

All responses to these questions are kept strictly confidential and are included in your clinical record.

PRESENTING PROBLEMS AND CONCERNS

Briefly describe the problem that you would like help with: _____

_____

_____

Are your problems affecting any of the following?

☐Handling everyday tasks	☐Self-esteem	☐Relationships	☐Hygiene
☐Work/school	☐Housing	☐Legal matters	☐Finances
☐Recreational Activities	☐Health	☐Sexual Activities	☐None of these.

Have you used any in the last 30 days? ☐Cigarettes/cigar/pipe ☐E-cig/vape pen ☐Snuff/chew ☐None

Have you attended AA/NA (or other social support group) in the last 30 days? ☐Yes ☐No

Have you ever had withdrawal symptoms when trying to stop taking any substances? ☐Yes ☐No

If yes, please describe: _____

Have you ever had problems with work, relationships, the law, etc. due to substance use? ☐Yes ☐No

If yes, please describe: _____

FAMILY AND DEVELOPMENTAL HISTORY

Family Mental Health Problems	☐ Mother/Mother's Family	☐ Father/Father's Family
Sexually Abused	☐ Mother/Mother's Family	☐ Father/Father's Family
Depression	☐ Mother/Mother's Family	☐ Father/Father's Family
Suicide	☐ Mother/Mother's Family	☐ Father/Father's Family
Anxiety/Panic Attacks	☐ Mother/Mother's Family	☐ Father/Father's Family
Anger/Abusive	☐ Mother/Mother's Family	☐ Father/Father's Family
Alcohol/Drug Abuse	☐ Mother/Mother's Family	☐ Father/Father's Family
OTHER:	☐ Mother/Mother's Family	☐ Father/Father's Family

Are your parents: ☐Legally married or living together? ☐Temporarily separated? ☐Divorced or permanently separated?

Mother remarried: _____ number of times

Father remarried: _____ number of times

What is the quality of your relationship with your:

Mother	☐Good	☐Poor	☐No Relationship	☐Other:_____
Father	☐Good	☐Poor	☐No Relationship	☐Other:_____
Step-Mother	☐Good	☐Poor	☐No Relationship	☐Other:_____
Step-Father	☐Good	☐Poor	☐No Relationship	☐Other:_____
Brothers/Sisters	☐Good	☐Poor	☐No Relationship	☐Other:_____
Spouse/Partner	☐Good	☐Poor	☐No Relationship	☐Other:_____
Children	☐Good	☐Poor	☐No Relationship	☐Other:_____

INTERPERSONAL / SOCIAL / CULTURAL INFORMATION

Who would you include in your social support network?

☐Family ☐Neighbors ☐Friends ☐Students
☐Co-workers ☐Community group ☐Support/Self-help group
☐Religious/spiritual center (which one)? _____

How important are spiritual matters to you? ☐Very ☐Somewhat ☐Not at all

Do you live: ☐By yourself or ☐With others? If you live with others, who do you live with?

_____

How long have you been in your current living situation? _____

Do you identify with a particular ethnic or cultural group? ☐Yes ☐No If yes, which one(s):

_____

Are ethnic or cultural issues causing difficulty in your life? ☐Yes ☐No If yes, please describe:

_____

LEGAL INFORMATION

Have you been arrested in the last 90 days? ☐Yes ☐No Number of times: _____
Have you been arrested in the last 30 days? ☐Yes ☐No Number of times: _____

Have you ever been convicted of a misdemeanor or felony? ☐Misdemeanor ☐Felony ☐Neither

If yes, please describe: _____

Are you currently involved in any divorce and/or child custody proceedings? ☐Yes ☐No

If yes, please describe: _____

MEDICAL INFORMATION

_____ _____
Physician (Name / Phone Number) Psychiatrist (Name / Phone Number)

_____ _____
Pharmacy / Location Drug Allergies

Do you have any psychiatric Advance Directives? ☐Yes ☐No (If yes, was a copy provided?)
Would you like more information on psychiatric Advance Directives? ☐Yes ☐No

MEDICATION INFORMATION: Please include prescription medications, over the counter (OTC) medications, herbal supplements, vitamins. If you need more space for more medications, please let reception know.

Medication Name	How much and How often?	Do they help? Any side effects/bad reactions?	Prescriber

_____
Signature of Person Completing Form PRINT Name of Person Completing Form

_____
Phone Number Date

FREMONT COUNSELING SERVICE
Child/Youth Intake – Additional Questions

Child's Name _____ Age _____ Date _____

All responses to these questions are kept strictly confidential.

Has the child attended school in the last three (3) months:
☐ Yes
☐ No – not attending school ☐ No – on summer Break ☐ No – attends daycare/preschool
☐ Unknown

Has the child been suspended from school in the last three (3) months:
☐ Yes - suspended ☐ No – not suspended ☐ Unknown

CUSTODIAL STATUS

Who has legal custody of the child? _____

Who has parental rights of the child?
Mother ☐ Yes ☐ No
Father ☐ Yes ☐ No

Who has physical custody of the child? _____

Speech functioning? ☐ Normal ☐ Some Problems ☐ Requires Assistance ☐ Should be Evaluated
Hearing functioning? ☐ Normal ☐ Some Problems ☐ Requires Assistance ☐ Should be Evaluated
Visual functioning? ☐ Normal ☐ Some Problems ☐ Requires Assistance ☐ Should be Evaluated

Are the child's immunizations up to date? ☐ Yes ☐ No ☐ Unknown

Is the child able to form and maintain relationships? ☐ Yes ☐ No ☐ Unknown

Is the child's housing situation stable? ☐ Yes ☐ No ☐ Unknown

Is the child at risk for an out-of-home placement? ☐ Yes ☐ No ☐ Unknown

Current school, grade, and teacher name (if known), OR current day/childcare situation:

_____

_____

Does the child have an IEP or MDT in place? ☐ Yes ☐ No ☐ Unknown
Does the child have behavior problems at school / daycare? ☐ Yes ☐ No ☐ Unknown
Has the child had any educational evaluations? ☐ Yes ☐ No ☐ Unknown
How does the child's intellectual functioning appear? ☐ Below Average ☐ Average ☐ Above Average

PARENT/GUARDIAN INVOLVEMENT

Are you (as the child's parent/guardian) able and willing to participate in the child's services as indicated?
☐ Yes ☐ No

Signature of Person Completing Form _____ Date _____

PRINTED Name of Person Completing Form _____ Phone Number _____

Fremont Counseling Service
Youth Intake Screen

1. Complain of aches or pains?	☐Never ☐Sometimes ☐Often
2. Spend more time alone than with others?	☐Never ☐Sometimes ☐Often
3. Tire easily? Have little energy?	☐Never ☐Sometimes ☐Often
4. Fidgety? Unable to sit still?	☐Never ☐Sometimes ☐Often
5. Have trouble with teachers?	☐Never ☐Sometimes ☐Often
6. Less interested in school?	☐Never ☐Sometimes ☐Often
7. Act as if they are driven by a motor?	☐Never ☐Sometimes ☐Often
8. Daydream too much?	☐Never ☐Sometimes ☐Often
9. Distract easily?	☐Never ☐Sometimes ☐Often
10. Are afraid of new situations?	☐Never ☐Sometimes ☐Often
11. Feel sad or unhappy?	☐Never ☐Sometimes ☐Often
12. Are irritable or angry?	☐Never ☐Sometimes ☐Often
13. Feel hopeless?	☐Never ☐Sometimes ☐Often
14. Have trouble concentrating?	☐Never ☐Sometimes ☐Often
15. Less interested in friends?	☐Never ☐Sometimes ☐Often
16. Fight with other children or siblings?	☐Never ☐Sometimes ☐Often
17. Absent from school?	☐Never ☐Sometimes ☐Often
18. School grades dropping?	☐Never ☐Sometimes ☐Often
19. Down on yourself/themselves?	☐Never ☐Sometimes ☐Often
20. Visit doctor for complaints, but nothing is physically wrong?	☐Never ☐Sometimes ☐Often
21. Have trouble sleeping?	☐Never ☐Sometimes ☐Often
22. Worry a lot?	☐Never ☐Sometimes ☐Often
23. Want to be with parent more than they have before?	☐Never ☐Sometimes ☐Often
24. Feel that you/they are bad?	☐Never ☐Sometimes ☐Often
25. Get hurt frequently?	☐Never ☐Sometimes ☐Often
26. Take unnecessary risks?	☐Never ☐Sometimes ☐Often
27. Seem to be having less fun?	☐Never ☐Sometimes ☐Often
28. Act younger than children your/their age?	☐Never ☐Sometimes ☐Often
29. Do not listen to rules?	☐Never ☐Sometimes ☐Often
30. Do not show feelings?	☐Never ☐Sometimes ☐Often
31. Do not understand other people's feelings?	☐Never ☐Sometimes ☐Often
32. Tease others?	☐Never ☐Sometimes ☐Often
33. Blame others for your/their troubles?	☐Never ☐Sometimes ☐Often
34. Take things that do not belong to you/them?	☐Never ☐Sometimes ☐Often
35. Refuse to share?	☐Never ☐Sometimes ☐Often
36. Do you/they have any emotional or behavioral problems for which you/they need help?	☐Yes ☐No

Fremont Counseling Service

CONSENT TO TREATMENT

Thank you for allowing Fremont Counseling Service (FCS) the privilege of serving you.

Client Name: _____

DOB: _____

CLIENTS' RIGHTS AND RESPONSIBILITIES

FCS supports and protects the fundamental human, civil, constitutional, and statutory rights of all of the people to whom we provide services. FCS complies with Federal civil rights laws and does not discriminate against or exclude people on the basis of race, color, national origin, age, disability, sex, gender identity, ethnicity, social or financial support, cultural beliefs, or type of mental health or substance use disorder.

· I understand that all individuals participating in treatment are expected to conduct themselves in an appropriate and respectful manner, and to protect the confidentiality of fellow clients.
· I agree that I will not share any personal or private information discussed in group activities/therapy, as applicable, by members of the group with anyone outside of the group.
· I understand that any aggressive, violent, or threatening behavior or violation of confidentiality of other clients may be the basis for exclusion from all, or some services.
· I consent to participate in the assessment of my need for specific treatment services.
· I agree to participate in the development of my treatment plan, to discuss treatment options, and to participate in identified treatment services and activities as indicated in that plan.
· I understand that I can receive copies of my treatment record if I request them. I understand that I have the right to be informed about specific services and procedures, including information about risks, benefits, and alternatives to each service proposed for my treatment.
· I understand that there is an expectation that I will benefit from services, but that there is no guarantee that this will occur.
· I understand that if I have a prior relationship with any staff member of FCS I will inform my provider so that we can discuss how best to protect my privacy to the fullest extent possible.

RIGHT TO REFUSE SERVICE

· I understand that I have the right to refuse or discontinue any service. If the issue of refusal should arise, it will be best for me or my legal guardian to discuss my treatment with my providers.

· In cases where treatment has been ordered by a court, I may refuse to participate in recommended treatment. However, there may be legal consequences from failure to follow the court ordered treatment.

· In the case of a minor or where incompetence exists, the legal guardian has the right of refusal.

SCHEDULING APPOINTMENTS

· I understand that if I am not able to attend my scheduled appointment, I will contact FCS at least 24 hours in advance to cancel or reschedule my appointment.

· I understand that if I do not show for a scheduled appointment, I will be charged a No Show fee.

· I understand that if I fail to show (No Show) for two (2) consecutive appointments that my services will be discontinued and my treatment record will be closed.

· I understand that if I do not have any contact with my service provider(s) for thirty (30) days that my services will be discontinued and my treatment record will be closed.

RECEIPT OF CLIENT HANDBOOK

I acknowledge that I was provided with a copy of the FCS Client Handbook, which includes information about FCS Privacy Practices, services and operations, including how to file a complaint/grievance about FCS staff or services. I understand that if I have questions about any of this information or other FCS operations, I can ask my service provider or any other employee of FCS at any time.

_____ Client or Parent/Guardian Initials

RECEIPT OF NOTICE OF PRIVACY PRACTICES

My initials below indicate that I was given the opportunity to review a hard copy of the FCS Notice of Privacy Practices. This information is also referenced in my copy of the Client Handbook and can be located on the FCS website: www.fremontcounseling.com/about/

_____ Client or Parent/Guardian Initials

RELEASE OF LIABILITY

If I participate in community based activities provided by FCS, I acknowledge that it is my responsibility to follow all safety rules during the activities. Therefore, I agree to hold harmless FCS, its staff members, contracted service providers and Board of Directors from any and all claims, losses, injuries, or other liabilities resulting directly or indirectly from participating in any and all activities associated with FCS programs or services.

_____ Client or Parent/Guardian Initials

PERMISSION TO SEEK NECESSARY MEDICAL CARE

For Adult Clients:

In the event of injury or illness that requires medical attention, I give permission for a representative of Fremont Counseling Service (or their related agents) to seek necessary medical care and hospital admittance.

_____ Client or Parent/Guardian Initials

For Minor Clients:

In the event of injury or illness that requires medication attention, and if I cannot be contacted, I give permission for a representative of Fremont Counseling Service (or their related agents) to seek the necessary medical care and hospital admittance of my child.

_____ Client or Parent/Guardian Initials

SIGNED AUTHORIZATION FOR CONSENT TO TREATMENT

I understand that services can only be provided to minor children (18 years and under) once the child's parent/guardian signs this Consent to Treatment. My signature below indicates that I understand all of the above and I authorize and consent for Fremont Counseling Service to provide mental health and/or substance abuse services for:

_____ Myself _____ My Child

I understand that this Consent to Treatment is effective for the duration of my treatment at FCS unless expressly revoked in writing. If/when I revoke this consent Fremont Counseling Service can no longer treat me.

If the client is not capable of understanding the nature of treatment and/or his/her need for it, and is therefore incapable of giving consent, the legal guardian must sign below. N/A is appropriate in emergency situations.

Parent/Guardian
Signature:_____ Date:_____

Staff Signature:_____ Date:_____

Revised 02/21/2023

Fremont Counseling Service

CONSENT TO TREATMENT BY TELEMEDICINE / TELEHEALTH

Client Name: _____

DOB: _____

CONSENT FOR TREATMENT BY TELEMEDICINE / TELEHEALTH

Healthcare services are available by two-way interactive video or telephone communications and/or by the electronic transmission of information. Referred to as “telemedicine” or “telehealth,” this means that I may be evaluated and treated by a healthcare provider from a different location (“offsite”).

I understand and agree to the following:

- I may choose to receive treatment from a healthcare provider that is at a different location from where I am (“offsite”).
- A nurse (or other designated staff) may remain with me (either in person or via telephone or video connection) to assist in the appointment.
- The offsite healthcare provider that provides my treatment will have access to all information included in my medical record at FCS and will keep a record of the treatment they provide to me in that record.
- Details of my medical/treatment history will be discussed with the offsite healthcare provider.
- I must give my verbal permission before anyone other than those identified service providers are to be present in my appointment.
- There are no additional charges or fees for services I will receive through use of the telemedicine system.
- My privacy and confidentiality will be protected as if I were receiving services from a provider in the office.
- Communication through the telemedicine system occurs over secure telecommunication lines dedicated solely for this purpose.
- No audio or video recordings of my sessions will be made.

Noting all of the above, I understand that my participation in “telemedicine” or “telehealth” is voluntary and that I further understand that I have the right to:

- Refuse the telemedicine appointment or stop participation in the telemedicine appointment at any time.
- If I choose not to participate in telemedicine at FCS for medication management services, I understand that I will have to go elsewhere for such services.
- Limit any physical examination proposed during the telemedicine appointment.
- Request that staff refrain from transmitting my information if I make the request before the information is transmitted.
- Request that non-medical personnel leave the room at any time.
- Request that all personnel leave the room to allow a private consultation with the off-site physician/healthcare provider.

I acknowledge that the physician/healthcare providers involved have explained the consultations in a satisfactory manner and that all questions that I have asked about the consultations/appointments have been answered in a manner satisfactory to me or to my representative.

Understanding the above, I consent to the telemedicine process described above for myself or as a parent / guardian by entering my full name on the line below.

Parent/Guardian
Signature:_____ Date:_____

Fremont Counseling Service
748 Main St
Lander, WY 82520-1234
Phone: 307-332-2231 | Fax: 307-332-9338

Client Name: _____

DOB: _____

ACKNOWLEDGEMENT OF FINANCIAL OBLIGATION

FCS is committed to meeting your healthcare needs and keeping our billing processes as simple as possible. In order to accomplish this in the most cost-effective manner for all of our clients we ask that you note the following:

- Fees will be billed to me for the services that I receive.
- Payment is expected at the time of service (when the service is received).
- I am responsible for making payments on my account in a timely and regular manner.
- I will not be denied services due to an inability to make payments on my account.
- I may be denied services for refusing to make payments on my account.

ELIGIBILITY FOR DISCOUNTED FEES

FCS receives funding from the State of Wyoming which allows us to discount fees for services based on household income and family size.

The funding that we receive for this purpose DOES NOT cover the full cost of your treatment.

In order to determine if you qualify for a discounted fee, please provide us with the following:

Monthly Income = $ Not Provided

Annual Income = $ Not Provided

Number of Individuals in Household = _____

==> FCS reserves the right to request updated monthly/annual income and household information at any time <==

Based on the above information, I am eligible for the following discount on my service fees:

5% 10% 20% 30% 40% 50% 60% 70% 80% 90% 95% 0% - No Discount

MY FEES FOR THE FOLLOWING SERVICES ARE:

* Mental Health Assessments, Individual and/or Family Therapy, and Case Management ($/hour) = **$120.00**
* Group therapy and/or Skills Training ($/hour) = **$60.00**
* Substance Abuse Assessments, with ASI/ASAM ($/hour) = **$240.00**
* Psychiatric Medication Management Services ($/hour) = **$240.00**

NO SHOW FEE AND LATE CANCELLATION FEE POLICY

* FCS will charge a fee of $25.00 for all missed (No Show) appointments AND for appointments that are not canceled with at least one (1) business day advance notice (without a legitimate reason).
* No Show / Cancellation fees are not covered by insurance, Medicaid, or Medicare.
* No Show / Cancellation fees will be billed directly to the client / responsible party.
* Multiple No Shows / Cancellations in any 12 month period may result in your case being closed by FCS.

COMMUNICATION WITH BILLING OFFICE

The accounts of clients that make timely and regular payments are considered to be in Good Standing. Clients with accounts that are Past Due or Delinquent will be expected to contact the FCS Billing Office to make arrangements for a reasonable payment plan for current services and past balances.

USE OF A COLLECTION AGENCY

FCS utilizes a collection agency to collect balances due on past due and delinquent accounts.

If a client fails to pay for services when they are rendered, or as noted on a signed payment plan, the client will be responsible for costs of sending the account to collections, including but not limited to:

Court costs I fees and attorney fees

A collections fee of thirty five percent (35%) of the unpaid balance will be added to the balance due.

SIGNED ACKNOWLEDGEMENT OF FINANCIAL OBLIGATION

My initials below indicate that I understand the financial obligation of the service(s) I am receiving and I agree to the terms of payment for said services as noted above.

_____ Client or Responsible Party Initials

I hereby assign all my rights to insurance/other benefits and instruct my insurance company or other third party payers to make payments directly to Fremont Counseling Service for the benefits/services provided.

_____ Client or Responsible Party Initials

I understand that FCS can request updated monthly/annual income and household information at any time in order to review/update my eligibility for discounted fees.

_____ Client or Responsible Party Initials

I have been notified of the fees I will be charged for FCS services provided.

_____ Client or Responsible Party Initials

I understand that I will be charged a $25.00 fee for missed (no show) and late cancel appointments.

_____ Client or Responsible Party Initials

I understand that it is my responsibility to contact the FCS Billing Office if I am unable to meet the financial obligations of services received as indicated in this Acknowledgement.

_____ Client or Responsible Party Initials

I understand that FCS sends Past Due and Delinquent Accounts to a collection agency when necessary.

_____ Client or Responsible Party Initials

Parent/Guardian Signature:_____ Date:_____

Staff Signature:_____ Date:_____

Fremont Counseling Service

Providing Mental Health and Recovery Services to Fremont County
An Equal Opportunity Provider
748 Main St., Lander, WY 82520 ~ (307) 332-2231, Fax (307) 332-9338
1110 Major Ave., Riverton, WY 82501 ~ (307) 856-6587, Fax (307) 856-2668

PROFESSIONAL DISCLOSURE AND CONFIDENTIALITY STATEMENT

Confidentiality:

We adhere to accepted professional standards of confidentiality. Unless you are an un-emancipated minor, no personal counseling information is released outside Fremont Counseling Service without your explicit authorization. In clinical relationships where un-emancipated minors are receiving treatment, personal counseling information can be accessed by or released to the parent/guardian of the minor without the minor's explicit authorization (unless it is otherwise stated that parent/guardian access is denied via a court order).

On March 1, 1999, Wyoming implemented a privileged communication statute. The law states that clients retain the right of privacy when involved in legal proceedings (civil, criminal, and juvenile) unless these specific circumstances exist:

a. abuse or harmful neglect of children, elderly, disabled, or incompetent individuals is known or reasonably suspected
b. the validity of a former client's will is contested
c. information related to counseling is necessary to defend against a malpractice action brought by a client
d. an immediate threat of physical violence against a readily identifiable victim is disclosed to the counselor
e. where an immediate threat of self-harm is disclosed to the counselor in the context of civil commitment proceedings
f. the client alleges mental or emotional damages in civil litigation or his/her mental or emotional state becomes an issue in any court proceeding concerning child custody or visitation
g. the client is examined pursuant to a court order
h. in the context of investigations and hearings brought by the client and conducted by the board, where violations of this act are at issue. (W.S.33-38-113).

Information deemed to be of a sensitive nature will be inspected by the Wyoming Mental Health Professions Licensing Board who will determine whether or not the information will become part of the record and subject to disclosure.

Professional Conduct/Code of Ethics:

Personal counseling relationships are strictly professional and contacts between clients and counselors are expected to be of a professional nature. Sexual intimacies between client and counselor are never appropriate, even after the therapeutic relationship has ended. Dual relationships are to be avoided if at all possible. We adhere to the Code of Ethics and standards of practice of one or more of the following: the American Counseling Association, the National Association of Social Workers, American Association for Marriage and Family Therapy, the National Association of Alcoholism and Drug Abuse Counselors, or the American Psychological Association.

Advanced Practice Nurses adhere to standards of practice of the American Nurses Association and are licensed by the Wyoming State Boards of Nursing.

This disclosure statement is required by the Wyoming Mental Health Professions Licensing Act. The Wyoming Mental Health Professions Licensing Board (2001 Capitol Avenue, Emerson Building Room 104, Cheyenne, WY 82002, (307) 777-3628) administers and enforces the requirements of the Act.

Board of Directors Contact:

Executive Director, 748 Main St., Lander, WY 82520 (307) 332-2231.

I have read and understand the information in this document.

Client Name: _____

Signature: _____ Date: _____

Revised 10.31.18

Fremont
COUNSELING SERVICE
Quality. Service. Progress. Recovery. Since 1959.

LANDER OFFICE
748 Main Street, Lander, WY 82520
Phone (307) 332-2231 • Fax (307) 332-9338

RIVERTON OFFICE
1110 Major Avenue, Riverton, WY 82501
Phone (307) 856-6587 • Fax (307) 856-2668

TTY HEARING IMPAIRED
1 (800) 877-9975

DATE_____

TO WHOM IT MAY CONCERN;

I (We) are providing room and board for _____
(PATIENT NAME)

In exchange for room and board household tasks are completed. These tasks can include, but not limited to; (Check all that apply)

- Household tasks ____
- Mowing/Trimming of the yard ____
- Snow Removal ____
- Auto Maintenance ____
- Other ____

Although the monthly value of the tasks above varies, the average monthly dollar value if the task is $_____. (Amount cannot be 0.00)

Please consider the dollar amount listed above as the monthly income for the purpose of figuring the sliding scale fee.

To the best of my knowledge the information contained above is true.

Signature of person providing room and board; _____
(SIGNATURE REQUIRED)

*If you are not working, or cannot provide pay stubs, please have a friend or family member complete this form for you. Fremont Counseling operates on a sliding scale fee. (See Attached) Without verification of income you will be charged the full amount.

Fremont Counseling Service
Fee Schedule
Effective FEBRUARY 1, 2024

Services will not be denied for inability to pay. However services may be denied for refusal of payment of the agreed upon fee.

We accept most insurance, Medicaid, Medicare and Kid Care (CHIP).

		MAXIMUM ANNUAL HOUSEHOLD INCOME											
	Poverty Level	100%	110%	120%	130%	140%	150%	160%	170%	180%	190%	200%	>200%
Household Size	1	15,060	16,566	18,072	19,578	21,084	22,590	24,096	25,602	27,108	28,614	30,120	30,121
Household Size	2	20,440	22,484	24,528	26,572	28,616	30,660	32,704	34,748	36,792	38,836	40,880	40,881
Household Size	3	25,820	28,402	30,984	33,566	36,148	38,730	41,312	43,894	46,476	49,058	51,640	51,641
Household Size	4	31,200	34,320	37,440	40,560	43,680	46,800	49,920	53,040	56,160	59,280	62,400	62,401
Household Size	5	36,580	40,238	43,896	47,554	51,212	54,870	58,528	62,186	65,844	69,502	73,160	73,161
Household Size	6	41,960	46,156	50,352	54,548	58,744	62,940	67,136	71,332	75,528	79,724	83,920	83,921
Household Size	7	47,340	52,074	56,808	61,542	66,276	71,010	75,744	80,478	85,212	89,946	94,680	94,681
Household Size	8	52,720	57,992	63,264	68,536	73,808	79,080	84,352	89,624	94,896	100,168	105,440	105,441
Household Size	9	58,100	63,910	69,720	75,530	81,340	87,150	92,960	98,770	104,580	110,390	116,200	116,201
Household Size	10+	63,480	69,828	76,176	82,524	88,872	95,220	101,568	107,916	114,264	120,612	126,960	126,961
		↓↓	↓↓	↓↓	↓↓	↓↓	↓↓	↓↓	↓↓	↓↓	↓↓	↓↓	↓↓
Discount		**95%**	**90%**	**80%**	**70%**	**60%**	**50%**	**40%**	**30%**	**20%**	**10%**	**5%**	**0%**
		↓↓	↓↓	↓↓	↓↓	↓↓	↓↓	↓↓	↓↓	↓↓	↓↓	↓↓	↓↓
Assessment and Individual/Family Therapy (per hour of service) Standard Fee = $120.00		$6.00	$12.00	$24.00	$36.00	$48.00	$60.00	$72.00	$84.00	$96.00	$108.00	$114.00	$120.00
Group Therapy (per hour of service) Standard Fee = $60.00		$3.00	$6.00	$12.00	$18.00	$24.00	$30.00	$36.00	$42.00	$48.00	$54.00	$57.00	$60.00
Case Management (per hour of service) Standard Fee = $120.00		$6.00	$12.00	$24.00	$36.00	$48.00	$60.00	$72.00	$84.00	$96.00	$108.00	$114.00	$120.00
Substance Abuse Assessment (per hour of service) Standard Fee = $240.00		$12.00	$24.00	$48.00	$72.00	$96.00	$120.00	$144.00	$168.00	$192.00	$216.00	$228.00	$240.00
Psychiatric Services (per hour of service) Standard Fee = $240.00		$12.00	$24.00	$48.00	$72.00	$96.00	$120.00	$144.00	$168.00	$192.00	$216.00	$228.00	$240.00

Cost to respond to subpoenas: Clinical Staff = $225 per hour (includes travel time and time waiting to be engaged).

Poverty guidelines will be revised as new information is released (board review/approval not required for guideline revisions).
Fees are reviewed/revised by the Fremont Counseling Service Board of Directors each year. January 2024

Poverty Guidelines Updated: January 15, 2024
Effective: February 1, 2024