

SAMARITAN COUNSELING CENTER OF THE NORTHWEST SUBURBS

NEW CLIENT INTAKE FORM

I. DEMOGRAPHICS

Date: ___/___/___

Thank you for choosing Samaritan Counseling Center. By answering the questions below as completely as you can, you will help us to understand you and your situation more fully. **ALL INFORMATION IS CONFIDENTIAL.**

Client's Name:	First M Last	Today's Date: / /	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
Address:	City	State	Zip Code County
Primary Phone #: () _____	Second Phone #: () _____	Spouse/Parent/Other Phone # () _____	
Can we leave a confidential message on your primary phone <input type="checkbox"/> Yes <input type="checkbox"/> No			
Can we leave a confidential message on your second phone <input type="checkbox"/> Yes <input type="checkbox"/> No			
Email Address:	Date of Birth: / / Age:		
Social Security Number:			
Ethnic Background: <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Asian American <input type="checkbox"/> Multicultural <input type="checkbox"/> Other: _____			
First M Last			
Guardian / Parent if Client under 18 years old :			
Which of the following categories best describes your household's total income before taxes last year? Please include from all sources such as salaries and wages, Social Security, retirement income, investments, and other sources.		<input type="checkbox"/> Less than \$20,000	<input type="checkbox"/> \$20,000 - \$39,999
		<input type="checkbox"/> \$40,000 - \$59,000	<input type="checkbox"/> \$60,000 - \$79,999
		<input type="checkbox"/> \$80,000 - \$99,999	<input type="checkbox"/> \$100,000 or more

How did you hear about Samaritan or who referred you: Website Psychology Today Insurance Human Service

Church Referral Name _____ Hospital Name _____

Family Friend Doctor Samaritan Staff or Board Member External Therapist Other _____

Faith / Denomination preference: _____

Congregation / House of Worship: _____

Emergency Contact

Name: _____ Relationship: _____

Address: Street: _____ City: _____ Zip Code: _____

Phone Number: ___ / ___ / _____

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II. FEE AGREEMENT

Who is responsible for the client's account?

Name(s): _____

Address (if different than above): Street _____ City _____ Zip Code _____

Phone Number (if different than above): () _____

Fees for Service: Samaritan Counseling Center (referred to as Center) offers the following options to pay for service. Please check the fee agreement that applies to your situation. Your selected fee agreement will be discussed and set with therapist during your first session:

I agree to pay the full fee for all sessions. I understand the fees for sessions are as follows:
\$200 intake \$145 regular \$185 extended \$185/ hour testing \$50 group

I will be using insurance the Center has contracted with to provide services. I agree to pay the co-payment or co-insurance as indicated by my insurance company. I understand I am financially responsible for all treatment the insurance company does not pay for including all applicable deductibles. I authorize the release of any medical or other information necessary to process the insurance claim. I authorize payment of medical benefits to Samaritan Counseling Center for services rendered.

Social Security Number of Primary Insured (if different than client): _____

Date of Birth of Primary Insured (if different than client): ____/____/____

I will be using Medicare benefits to pay for my counseling. I understand that not all Center counselors are able to accept Medicare reimbursement and I have discussed this with my counselor. I understand I am financially responsible for all treatment that Medicare or other insurance does not pay for. I have read and signed the Advance Beneficiary Notice of Non-coverage.

I require a fee adjustment. I have supplied the Center with proof of current income. I understand that this fee will be reviewed if my financial situation changes. I also understand the agency reviews such fees periodically and that my fee may change over time.

To be completed by therapist and initialed by person with financial responsibility for client

I accept Samaritan's adjustment to \$_____ per session, which I will pay at each session. In addition, I understand this fee adjustment is limited to _____ sessions. Authorized Initials _____

I was referred by my clergy with pre-approval of payment through my place of worship.

I was referred by employer's Employee Assistance Program (non-CIGNA program).

Because counseling hours are reserved, Samaritan **charges \$100 for canceled sessions when less than 24 hours' notice** is given or **client does not show** for scheduled appointment. This charge is not covered by insurance. There will be a **\$25** service charge on all **returned checks**.

Client or Authorized Person's Signature for Fee Agreement in its Entirety

Print Name: _____

Signature: _____ Date: ____/____/____

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III. CONSENT FORMS

A. THERAPY INFORMATION AND DISCLOSURE STATEMENT

The Samaritan Counseling Center of the Northwest Suburbs (“Center”) welcomes you as a potential client. We believe it is important for you to be informed about the nature of counseling or psychotherapy, the policies and procedures governing the help you will receive here, the fees charged for our services, and your rights as a client. At the end of this statement there is a place for you to sign, signifying your general consent for therapy.

Counseling and Psychotherapy in this Center: The words *counseling* and *psychotherapy* (referred to below as “therapy”) are often used interchangeably to indicate forms of psychological help that address various kinds of personal and family distress such as depression, anxiety, adjustment difficulties at work and with other people, and marital and family conflicts. The goals of therapy range from the relief of symptoms to significant life change based on acquiring a better understanding of one’s personal, interpersonal, and social circumstances.

The Samaritan Center’s methods of treatment are derived from evidence-based techniques and standard best practices common to the training and experience of psychotherapists, marriage and family therapists, psychologists, social workers, and pastoral counselors. Practitioners in this Center work within the standards and ethical guidelines of state licensing laws, of professional associations, and of the Samaritan Institute. Samaritan therapists are also able to respond to the spiritual needs of clients whose values and beliefs may be part of a religious affiliation. Spiritual practice is found to make a difference in the process of changing and growing, and you may feel free to discuss this in your therapy. There is no expectation that clients have a spiritual practice, and none will be promoted. We follow your lead in this regard.

Therapy Process: Therapy begins with an *intake process* designed to evaluate your needs and difficulties and to help you and the therapist make a decision about engaging in therapy. This may take one or more sessions. If becoming a client here does not seem feasible, we can assist you in selecting a more appropriate place for the help you need. The *therapy process* itself may take many forms, depending on the issues that need to be addressed and how far you wish to go in addressing them. Treatment is guided by a *treatment plan* that you and your therapist both agree to pursue. Therapy ends when the work is done, or at the point you decide to terminate. Clients are entitled to receive information from therapists about their credentials, education, methods of therapy, the possible duration of therapy, and fees. Your therapist will disclose this information in the initial interview/s.

Therapy Policies and Procedures:

Your Rights as a Client: You are entitled to the rights established by the state of Illinois governing clinical practices. These include the rights of consent to treatment; seeking disclosure from your therapist about his or her qualifications; requesting a different therapist; ending treatment at any time; accessing the client grievance procedures; and having the records of your treatment kept in confidence (see confidentiality statement below).

Confidentiality: What you tell your therapist will be kept strictly confidential and will not be revealed to other persons or agencies without your written permission, except when mandated by state and federal statutes, and as part of the professional practice of this Center. By law, there are circumstances when the therapist must report information to the appropriate persons or agencies, for example: a) if you threaten bodily harm or death to yourself or someone else; b) if you reveal information about child or parental physical or sexual abuse; and c) if ordered by a court of law. If your therapy is court ordered, the results of treatment or tests must be revealed to the court. Also, in keeping with standard professional practice, your case records may be viewed by the Center staff, consultants, and accreditation reviewers for purposes of diagnosis, treatment, and quality assurance. Confidentiality is maintained by all persons involved in the consultation. Except for the above stated instances, your written permission is required before your therapist or the Center can reveal information about your treatment. In addition, you have the right to be notified if there is a breach of unsecured Protected Health Information. Protected Health Information (“PHI”) is defined as “any information, in any format, that could be used to identify you either in the past, present, or future.” You also have the right to opt out of fundraising communications or any use or disclosure of PHI for marketing purposes or sale of your PHI. You also have the right to sign an authorization for most uses and disclosures of psychotherapy notes. You will be asked to sign an authorization before any Protected Health Information is released for any uses and disclosures not

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described in this Disclosure Form. If you pay the full therapy fee out of pocket you may be entitled to restrict certain disclosures of Protected Health Information to your insurance carrier.

Client Litigation: The Samaritan Counseling Center will not voluntarily participate in any litigation or custody dispute in which you or your representative and another individual, or entity, are parties. We have a policy of not communicating with Representative's attorney and will generally not write or sign letters, reports, declarations, or affidavits to be used in Patient's or Representative's legal matter. We will generally not provide records or testimony unless legally compelled to do so. If we are ordered by a court of law to appear as a witness in an action involving you or your representative, you agree to reimburse your therapist for any time spent for preparation, travel, or other time in which your therapist has made him/ herself available legally at an hourly rate of \$600.00. In addition, we will not make any recommendations as to custody or visitation regarding clients that are minors. Effort will be made to be uninvolved in custody disputes, but the Center will refer to custody mediators and/or forensic psychologists if needed.

Fees and Payment: The therapy Fee Agreement that you will complete in the intake interview will state your fee and payment requirements. We request payment at the time of your therapy appointment. You may pay by cash, check or credit card.

Insurance and Other Third-Party Payments: If you have insurance or other third-party coverage (e.g., a managed care organization or employee assistance program) that covers therapy, you are responsible for giving the Center the necessary information to file accurate and complete claims on your behalf. The Center does not guarantee that your insurance or other coverage will pay your claim. *You are responsible for the account balance, and deductibles and co-payments required by the insurance or third-party company.*

Terminating Therapy: Although you may end therapy at any time, it is preferred that you have at least one face-to-face concluding appointment with your therapist rather than terminating by telephone, mail, or by not showing up for your appointment. At the time of discharge, clients are given or sent a Client Satisfaction Survey that invites feedback on the therapy process. We appreciate your input as it is a valuable tool for the Center to evaluate its overall services.

- I have read the information contained in this Therapy Information and Disclosure Statement
- I consent to treatment as described in the Therapy Information and Disclosure Form, and will pay for my therapy expenses as prescribed in the Financial Agreement.

Client (12 and over): Print Name: _____

Signature: _____ Date: ____/____/____

Parent or Legal Guardian of a Minor: Print Name: _____

Signature: _____ Date: ____/____/____

Witness: Print Name: _____

Signature: _____ Date: ____/____/____

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**B. NOTIFICATION OF OBLIGATION TO INFORM
PRIMARY CARE PHYSICIAN OF MENTAL HEALTH SERVICES**

Pursuant to Illinois law, you are hereby informed that it is desirable that you confer with your primary care physician, if you have one. I am required to notify him/her that you are seeking or receiving mental health treatment unless you waive such notification. Please indicate your wishes:

_____ I waive notification of my primary care physician that I am seeking or receiving mental health services and I direct you NOT to so notify him/her.

_____ I do not have a primary care physician and do not wish to see or confer with one. I therefore WAIVE NOTIFICATION that I am seeking or receiving mental health services.

Date: _____ Recipient: _____

Date: _____ Therapist: _____

OR

AUTHORIZATION OF NOTICE AND RELEASE OF INFORMATION

I do not waive notice to my primary care physician. I hereby authorize _____
(Therapist Name)
to notify my primary care physician, Dr. _____, of _____
that I am receiving mental health services. This authorization will be effective for _____ months (not exceeding 12 months) from the date below. I recognize that the consequence of my refusal to sign this authorization is that I will be asked to sign the above waiver, if I did not do so initially.

Date: _____ Recipient: _____
(Parent or guardian of Recipient, if Recipient is under 12)

Date: _____ Therapist: _____

NOTIFICATION TO PRIMARY CARE PHYSICIAN OF PATIENT RECEIVING MENTAL HEALTH SERVICES

Pursuant to Illinois law, you are hereby notified that _____
Patient Name
is seeking or receiving mental health services from me. The patient has signed the above authorization for Release of Information, a copy of which I am enclosing for your record. I look forward to the opportunity to confer with you about this patient as the occasion or need arises.

Date: _____ Therapist: _____

Note: A new release must be signed to authorize ongoing communication with the primary care physician following the expiration of the above release.

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C. CREDIT CARD AUTHORIZATION

Cardholder Name: _____

Billing Address: _____

City _____ State: _____ Zip Code: _____

Credit Card Type: Visa MasterCard Discover

Credit Card Number: _____

Expiration Date: _____

Last 3 digits located on the back of the credit card: _____

I authorize Samaritan Counseling Center of the Northwest Suburbs to charge my credit card \$ _____ for each of my regular sessions.

I authorize Samaritan Counseling Center of the Northwest Suburbs to charge my credit card one time for \$ _____.

I authorize Samaritan Counseling Center of the Northwest Suburbs to charge \$100 to my credit card for a missed appointment when I fail to give 24 hours' notice by voice mail to my therapist.

I authorize Samaritan Counseling Center of the Northwest Suburbs to charge to my credit card for any unpaid balance for which I am responsible that is 120 days old or more, including co-payments.

You will be notified when any charge is applied to your credit card as a result of the above actions. If your card is charged in error, you will be reimbursed in full.
Please pay your portion at the time of service to avoid use of this authorization.

Cardholder – Print Name, Sign and Date Below:

Name: _____

Signature: _____

Dated: _____