SAMARITAN COUNSELING CENTER OF THE NORTHWEST SUBURBS

NEW PATIENT INTAKE FORM FOR DR. KATHRYN SINGER

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.**

Patient's Name: First M Last	Today's Date: / / Gender: ☐ Male ☐ Female ☐ 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 ☐ Yes ☐ No
Can we leave a confidential message on your second phone ☐ Yes ☐ No

Email Address:	Date of Birth: ______/______/______ Age: ______
Social Security Number:	

Ethnic Background:
☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian American ☐ Multicultural ☐ Other:______________

Guardian / Parent if Patient under 18 years old : First M Last

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.	☐ Less than $20,000	☐ $20,000 - $39,999
	☐ $40,000 - $59,000	☐ $60,000 - $79,999
	☐ $80,000 - $99,999	☐ $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: ____ / _____ / __________

For Office Use:

Diagnosis Code: _______________________

Billing Special Instructions:

____

____

Created: 07/23/2014
Revised: 09/20/2016

II. FEE AGREEMENT

Who is responsible for the patient'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 the doctor during your first session:

☐ I agree to pay the full fee for all sessions. I understand the fees are as follows:
$300 intake session $150 regular session   Missed appointment without 24 hr. notice $100.

☐ 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 patient): __________ ________ ____________

Date of Birth of Primary Insured (if different than patient): ______/______/_______

☐ I will be using Medicare benefits to pay for my psychiatry services. **I understand I am financially responsible for all treatment that Medicare or other insurance does not pay for.**

☐ 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 Dr. Singer and initialed by person with financial responsibility for patient

☐ 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.

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

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

Print Name: ______________________________________

Signature: ____ Date: ____/_____/______

III. CONSENT FORMS

A. TREATMENT INFORMATION AND DISCLOSURE STATEMENT

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

Psychiatry and Psychotherapy in this Center: The goals of psychotherapy and psychiatric care include the relief of symptoms and a long-term improvement in quality of life based on acquiring a better understanding of one's personal, interpersonal, and social circumstances and effective medications, if needed.
Practitioners in this Center work within the standards and ethical guidelines of state licensing laws, of professional associations, and of the Samaritan Institute. Samaritan psychotherapists are also able to respond to the spiritual needs of patients 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 patients have a spiritual practice, and none will be promoted. We follow your lead in this regard.

Psychiatric Process: Psychiatric therapy begins with an *intake process* designed to evaluate your needs and difficulties and to help you and the doctor make a decision about how to address your individual symptoms. This may take one or more sessions. If becoming a patient here does not seem feasible, we can assist you in selecting a more appropriate place for the help you need. The *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 and medication are guided by a *treatment plan* that you and your doctor both agree upon. Psychiatric care ends when medication is no longer needed. Patients are entitled to receive information from the doctor about their credentials, education, methods of diagnosis, the possible duration of therapy, and fees. Your doctor will disclose this information in the initial interview/s.

Treatment Policies and Procedures:

Your Rights as a Patient: 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 doctor about his or her qualifications; requesting a referral to a different doctor; ending treatment at any time; accessing the patient grievance procedures; and having the records of your treatment kept in confidence (see confidentiality statement below).

Confidentiality: What you tell your doctor 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 doctor 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 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.*

Patient 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 patients 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 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) 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 Treatment: Although you may end treatment at any time, it is preferred that you have at least one face-to-face concluding appointment with your doctor rather than terminating by telephone, mail, or by not showing up for your appointment. At the time of discharge, patients are given or sent a Patient 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 Treatment Information and Disclosure Statement

☐ I consent to treatment as described in the Treatment Information and Disclosure Form, and will pay for my treatment expenses as prescribed in the Financial Agreement.

Patient (12 and over): Print Name: ____

Signature: ____ Date: ____/_____/______

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

Signature: ____ Date: ____/_____/______

Witness: Print Name: ____

Signature: ____ Date: ____/_____/______

B. NOTIFICATION OF DESIRABILITY OF INFORMING 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. Your psychiatrist is required to notify him/her that you are seeking or receiving psychiatric treatment unless you waive such notification. Please indicate your wishes:

_______ I direct you NOT to NOTIFY my primary care physician that I am seeking or receiving psychiatric treatment.

_______ I do not have a primary care physician.

_______ Please notify my primary care physician that I am receiving psychiatric treatment. I am willing to sign a release form so that my psychiatrist can notify my primary care physician that I am receiving treatment.

Patient (12 and over): Print Name: ____

Signature: ____ Date: ____/_____/______

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

Signature: ____ Date: ____/_____/______

Witness: Print Name: ____

Signature: ____ Date: ____/_____/______

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 $150 to my credit card for a missed appointment when I fail to give 24 hours' notice by voice mail to my psychiatrist.

☐ 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: ____