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		
Gender: ☐ Male ☐ Female ☐ Other				
Address:	City	State	Zip Code	County
Primary Phone #: ( ) _____	Second Phone #: ( ) _____	Spouse/Parent/Other Phone # ( ) _____		
On which phone(s) may we leave a confidential message: ☐ Primary ☐ Secondary ☐ Other				
Email Address:	Date of Birth: _____/_____/_____ Age: _____			
Ethnic Background: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian American ☐ Multicultural ☐ Other:_____				
First M Last Guardian / Parent if Client under 18 years old :				
Income information is used anonymously. Names are always omitted; only categories are used for grants. Your response is optional, but greatly appreciated.	☐ 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 _____

Do you have a spiritual practice or faith walk? If so, please indicate house of worship, tradition, or practice:

_____

Emergency Contact

Name: _____ Relationship: _____

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

Phone Number: ____ / _____ / _____

For Office Use:

DX Code: _____

Billing Special Instructions:

_____

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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 offers options to pay for service. Please select how you plan to pay for services. The fee agreement you select will be confirmed with your therapist during your first session:

☐ I agree to **self-pay** for all sessions at the time of service. I understand the fees for sessions are as follows:
$200 intake $145: 45 minute session $185: 60 minute session $50: 45 minute group session
$35: 15 minute phone session $135: 45 minute tele-mental health session

☐ I will be using **in-network insurance**. I agree to pay the co-payment, co-insurance or deductible fee as indicated by my insurance company, at the time of service. I understand that, for whatever reason, my insurance company does not reimburse Samaritan for services, I am responsible for those charges. In order to process insurance claims, I authorize the release of necessary personal or health information. I authorize payment of medical benefits to Samaritan Counseling Center for services rendered.
Date of Birth of Primary Insured (if different than client): _____/_____/_____

☐ I will be using **Medicare benefits**. I understand I am financially responsible for all treatment that Medicare or other secondary insurance does not pay for. I have read and signed the Advance Beneficiary Notice of Non-coverage.

☐ I require **fee assistance**. I have supplied Samaritan with proof of current income. I agree that if my financial situation changes, I will inform my therapist. I understand Samaritan reviews fees regularly and that this fee assistance may change.

☐ I accept Samaritan's adjustment to $___ per session, which will be paid at time of service.

☐ I was referred by an Employee Assistance Program. Company/Employer name _____

Please be aware that Samaritan **charges $100 for canceled sessions when less than 24 hours' notice** is given or **client does not show** for scheduled appointment, except for emergencies acknowledge by your therapist. This charge is not covered by insurance. There is a **$25** service charge on all **returned checks.**

☐ I have read and understood my obligation to pay for my therapy expenses as prescribed in the above Fee Agreement.

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

Print Name: _____

Signature: _____ Date: ____/_____/_____

III. CONSENT FORMS

A. THERAPY INFORMATION AND DISCLOSURE STATEMENT

The Samaritan Counseling Center of the Northwest Suburbs welcomes you. 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 counseling 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 at Samaritan: 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 emotional, mental, relational or behavioral distress such as depression, anxiety, grief, workplace hostilities, school bullying, and marital or family conflicts. The goals of therapy range from the relief of symptoms to significant life changes based on new skills or techniques for coping, innovative therapies, and/or a better understanding of one's personal, interpersonal, and social circumstances.
The Samaritan Center uses evidence-based techniques that are standard practice for psychologists, social workers, and professional counselors. Samaritan strictly adheres to the professional and ethical guidelines of Illinois licensing laws, and of professional associations. Samaritan therapists are also able to respond to clients who have a spiritual practice or religious tradition. Spiritually-integrated counseling offers a holistic, mind-body-spirit approach to therapy and may be beneficial for some clients. *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 current physical, emotional and mental circumstances, and helps clarify for your therapist your decision to seek therapy. This may take one or more sessions. If your needs and treatment are beyond the scope of what Samaritan can offer, we will provide resources to assist you in finding the right fit. 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 goal of the treatment plan is achieved, or there is a decision to postpone or stop therapy.

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 Samaritan's professional, clinical practice. 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 reviewed by the Clinical staff for purposes of consultation, diagnosis, treatment, and quality assurance, and are always kept confidential. Except for the above stated instances, your written permission is required before your therapist or anyone at Samaritan will 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 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 have opted for **self-pay** (out of pocket) you have no obligation to release any 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, 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. Every effort will be made to be uninvolved in custody disputes. Samaritan will refer you to custody mediators and/or forensic psychologists if needed.

Fees, Insurance and Other Third-Party Payment: The therapy Fee Agreement in the above section of this form indicates your consent to pay your portion of the fee at time of service. If you use 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 current information to file accurate and complete claims on your behalf. Samaritan does not guarantee that your insurance or other coverage will pay your claim. *You are responsible for the account balance, deductibles and co-payments that may, for whatever reason, go unpaid by the insurance or third-party company.*

Terminating Therapy: Good therapeutic practice is to have at least one face-to-face concluding appointment to wrap up therapy, rather than terminating by telephone, text, email, letter, or simply not showing up for future appointments. Shortly after therapy is complete, clients are sent a Client Satisfaction Survey that invites feedback on the therapy process and other aspects of Samaritan Counseling Center. Your participation is entirely voluntary, but we appreciate your input as it helps evaluate and improve our services.

☐ I have read and understood the information contained in this Therapy Information and Disclosure Statement and consent to treatment described therein.

Client (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 Public Health Act 410 ILCS 50, you are hereby informed that it is desirable that you confer with your primary care physician, if you have one. Your therapist is required to notify him/her that you are seeking or receiving mental health treatment unless you waive such notification. Please indicate your wishes:

_____ I understand it is beneficial for consistent and sound care to inform my primary care doctor of my therapy at Samaritan. I consent to notification of treatment by my counselor to my primary doctor.

Name of Doctor:_____

Address:_____

Phone: _____

_____ Do NOT to NOTIFY my primary care physician that I am seeking or receiving mental health services. I decline to have this information shared with my doctor.

_____ I do not have a primary care physician at this time.

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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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 the agreed upon fee for regular sessions at $_____.

☐ I authorize Samaritan Counseling Center of the Northwest Suburbs to charge my credit card one time intake fee 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 60 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 fee at the time of service to avoid an accrued balance.

Cardholder – Print Name, Sign and Date Below:

Name: _____

Signature: _____

Dated: _____