

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: / / /
Address: City State Zip Code County	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
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: _____	
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.	<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: ____ / ____ / _____

For Office Use:

Diagnosis Code: _____

Billing Special Instructions:

SAMARITAN COUNSELING CENTER OF THE NORTHWEST SUBURBS

NEW PATIENT INTAKE FORM FOR DR. KATHRYN SINGER

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) charges the following for service.

- 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.

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. 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: ____/____/____

SAMARITAN COUNSELING CENTER OF THE NORTHWEST SUBURBS

NEW PATIENT INTAKE FORM FOR DR. KATHRYN SINGER

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

SAMARITAN COUNSELING CENTER OF THE NORTHWEST SUBURBS

NEW PATIENT INTAKE FORM FOR DR. KATHRYN SINGER

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.

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.

- 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: ____/____/____

SAMARITAN COUNSELING CENTER OF THE NORTHWEST SUBURBS

NEW PATIENT INTAKE FORM FOR DR. KATHRYN SINGER

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: ____/____/____

SAMARITAN COUNSELING CENTER OF THE NORTHWEST SUBURBS

NEW PATIENT INTAKE FORM FOR DR. KATHRYN SINGER

C. CREDIT CARD AUTHORIZATION

Cardholder Name: _____

Billing Address: _____

City _____ State: _____ Zip Code: _____

Credit Card Type: Visa MasterCard Discover American Express

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 \$300.00 for my initial intake session and \$150.00 for each of my regular half hour sessions.

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 psychiatrist.

I authorize Samaritan Counseling Center of the Northwest Suburbs to charge to my credit card for any unpaid balance.

You will be notified when any charge is applied to your credit card as a result of the above actions by email. If your card is charged in error, you will be reimbursed in full.

Cardholder – Print Name, Sign and Date Below:

Name: _____

Signature: _____

Dated: _____