



SAMARITAN CENTER

The Path to Wellness

INFORMATION ABOUT CENTER SERVICES

Welcome to the Center and thank you for choosing to use our services. It is important for you to be informed about the nature of psychotherapy, the policies and procedures governing the help you will receive here, the fees for our services, and your rights as a client. In this package there is a place for you to sign, indicating your general consent to treatment.

Psychological Testing: Psychological testing may be indicated before you begin therapy or at some point in the course of therapy. Your counselor can discuss these options with you. Psychological tests use samples of behavior in order to assess cognitive and emotional functioning about a given individual.

Psychotherapy: "Counseling" and "psychotherapy" (therapy) are often used interchangeably to indicate forms of psychological help that address various kinds of personal and family distress (e.g., depression, anxiety, marital conflicts). The goals of therapy range from the relief of symptoms to significant life change as one gains a better understanding of personal, interpersonal, and social circumstances.

The Center's clinical staff is comprised of licensed psychologists, licensed professional counselors, licensed social workers, licensed marriage and family therapists, pastoral counselors and specialists with certifications in special areas of practice. We also have therapists-in-training working under the supervision of licensed therapists to obtain advanced degrees or to meet eligibility standards for licensure. All staff work within the standards and ethical guidelines of state licensing laws, professional associations, and the national accreditation standards of the Samaritan Institute. (A statement of Professional and Clinical Standards is available on request.)

Therapy Process: Therapy begins with an *intake interview* to evaluate your needs and difficulties. Your therapist will work with you in determining the best course of treatment. Therapy has been shown to have many benefits (e.g., better relationships, solutions to specific problems, significant reductions in feelings of distress). Progress in therapy depends on several factors including regular attendance, talking openly with your therapist, motivation, effort, and life circumstances.

You and your therapist will decide together when your therapy is complete, but you may choose to withdraw at any time. If you decide to withdraw, it is recommended that you have at least one final appointment with your therapist rather than terminating by telephone, mail, or by not showing up. Periodically during therapy, you may be asked to complete a survey about your progress. Your answers are used to make adjustments to the therapy process and to assist the Center in assessing the strengths and weaknesses of our services.

The Samaritan Center believes in a spiritually integrated approach to treatment and we have expertise in including your faith/spiritual beliefs and practices as a part of the therapeutic process. It is our philosophy to work within your own belief system. Our therapists will not impose their personal beliefs upon you and will include discussion of spirituality/religion/faith in accordance with your expressed wishes.

Your Rights as a Client.

You have all of the rights established by the State of Texas governing clinical practices. These include:

- The right of consent to treatment,
- The right to seeking disclosure from your therapist about his or her qualifications,
- The right to requesting a different therapist,
- The right to end treatment at any time,
- The right to access the client grievance procedures,
- The right to have your clinical record kept private (see "Confidentiality" below),
- You also have the right to have any tests, procedures, and recommendations explained to you in simple terms, and you have the right to refuse such tests, procedures, or recommendations.

Confidentiality: What you tell your therapist will be kept confidential and will not be revealed to other persons or agencies without your written permission, except when mandated by state and federal statutes, court order, or as part of the professional practice of this Center. We believe in an integrated approach to wellness and may share information about you to other medical and/or mental health providers within or outside of the Center in order to maximize your treatment outcomes. For further information please see our *Notice of Privacy Practices* and *Privacy Practices Acknowledgement*. Feel free to ask for clarification about anything you do not understand. Your privacy is very important to us, and we want to do everything possible to protect it.

Fees and Payment: The regular fee is \$120.00 for a 55-minute session for most counseling services and \$150.00 for the initial session. If you cannot afford the regular fee, the Center may adjust your fee taking into account your income and number of family members. Proper documentation is required. Payment of your agreed upon fee is due at the time of your appointment unless prior arrangements have been made. You may pay by cash, check or credit card.

Returned Checks and Rejected Credit Card Charges: A \$25 fee is charged on all checks returned for non-sufficient funds and rejected credit card charges.

Insurance and Other Third-Party Payments: If you wish to use insurance or other third-party coverage (e.g., a managed care organization or employee assistance program) to pay for therapy, you are responsible for providing the Center with accurate and complete information. The Center does not guarantee that your insurance or other coverage will pay your claim. You are responsible for the account balance and for deductibles and co-payments required by your insurance or third-party payer.

Insurance & Confidentiality: You should be aware that your contract with your health insurance company requires that the Center provide the company with information relevant to the services you receive. At a minimum, we are required to provide a clinical diagnosis. Some companies require additional information such as treatment plans, summaries, or copies of your entire clinical record. We make every effort to release only the minimum information necessary for the purpose requested. This information will become a part of the insurance company files. Though all insurance companies claim to keep such information confidential, we have no control over what they do with your private information once it has been released to them.

Appointments and Cancellations: If an appointment is missed or canceled with less than 24 hours notice, you will be charged for that session. We would prefer that you give us 48-hour notice of cancellation so that we might schedule someone else in that appointment time. This charge is not covered by insurance. If you use insurance to pay your fee, the fee will be the combination of the copay and the amount paid by insurance (the contract rate). If you are paying privately, you will be charged the fee you normally pay for a counseling session (minimum charge of \$20 for a missed session). If you miss an appointment two weeks in a row or twice in one month, you will lose your recurring appointment time. We ask for a two-week notification of your plans to terminate treatment.

Legal Proceedings: The staff of the Center **does not provide testimony in legal proceedings.** However, if you choose to subpoena your therapist or your records, you agree to pay for any required preparation time, for your therapist's time out of the office, and for travel at a charge that may equal or exceed the Center's hourly rate.

Emergencies: The Center does not provide "emergency services". If you have an urgent concern, we try to schedule an appointment as soon as possible. If you have a critical emergency, contact one of the following: Center on-call staff (512) 656-5517 (note that this is a wireless phone and is therefore not a secure line) or the MHMR Hotline (512) 472-4357. After-hours messages can be left on the Center's voice-mail system, but do not leave an urgent message since these messages may not be reviewed until the next business day.

Grievances: You are encouraged to talk first with our staff about any concerns you may have about our services; however, if you prefer, you may file a formal grievance with the Clinical Director within 45 days of the time you become aware of a problem. We will investigate and attempt to resolve it within 30 days. If the problem is not resolved, the Center's CEO will investigate and prepare a written decision within 10 days. You may appeal the CEO's decision directly with the Center's Board of Directors within 14 days. The decision from the Board of Directors is final. You will not be threatened or penalized in any way for presenting your concerns informally by talking with staff, or formally by filing a grievance.

Consumer Complaint Hot-Lines: Licensed Professional Counselors and Licensed Marriage and Family Therapists (800) 942-5540; Social Workers (800) 232-3162 or in Austin 719-3521; Licensed Psychologists (512) 305-7709; Pastoral Counselors (703) 385-6967.

PERSONAL INFORMATION FORM

Date _____

Please complete all information requested. Complete one form for each person that will participate in counseling.

First Name _____ Middle Initial _____ Last Name _____

Birth Date ____/____/____ Age _____ Gender: Male Female

Address _____ City _____ State _____ Zip _____

County _____ Email Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Which ONE number may we use to leave messages and appointment reminders? Home? Work? Cell?

May we also contact you by Email? Text to Cell? Letter?

Emergency Contact: Name _____ Phone Number _____

If applicable, an alternative mailing address for billing statements:

Address _____ City _____ State _____ Zip _____

Name(s) of Primary care provider and/or Psychiatrist: _____

Please complete the following information required by our grant funding:

Are you a military: Current Service Member Veteran Family member N/A

Relationship to Veteran or Service Member: _____

*PLEASE PROVIDE DD214 or MILITARY ID to qualify for our HOPE FOR HEROES programs and discounts

If you are part of a military family, have you or a family member been previously deployed to Iraq/Afghanistan

currently deployed to Iraq/Afghanistan

Ethnicity: African- American Anglo/Caucasian Asian Hispanic/Latino Native American Other

Annual Household income: \$ _____ Number of people living in household: _____

INSURANCE Information:

Primary Insurance: _____ Member ID _____ Group # _____

Policy Holder Name: _____ Policy Holder Date of Birth _____

Policyholder Social Security #: _____ Is this a Medicare plan? _____ (yes or no)

Secondary Insurance: _____ Member ID _____ Group # _____

Policy Holder Name: _____ Policy Holder Date of Birth _____

Policyholder Social Security #: _____ Is this a Medicare plan? _____ (yes or no)

Will someone other than yourself be responsible for payments? Yes No If Yes, please complete the following:

(This section required for minors)

Organization (if applicable): _____

Person: First Name _____ Last Name _____ Phone# _____

Address _____ City _____ State _____ Zip _____

Insured or Responsible person's signature: Insured or Responsible person's signature: I consent and authorize the Samaritan Center to release medical or other supporting information necessary to process my insurance claims and/or for collecting payment from the above person/organization. I authorize payment of medical benefits to The Samaritan Center. *I understand that I am responsible for all deductibles and co-pays. I understand that I am responsible for 100% of my charges if I am a Private Pay client. I understand all charges and copays are due at time of service. I understand that I must inform the Samaritan Center if my insurance is a **Medicare or Medicaid** plan and that if I do not, I am waiving my rights to use my **Medicare or Medicaid** insurance plan and I will be responsible for all charges and copays.*

Printed Name: _____ Signature: _____ Date: _____

FINANCIAL WORKSHEET
FOR PRIVATE PAY, REDUCED-FEE CLIENTS ONLY

Determination of Fees for Counseling:

If you do not have insurance/EAP and cannot afford our full fee for counseling, you may be eligible for a reduced fee. Please complete the information below **and provide proper documentation to verify income.**

Part 1 Monthly Family/Household Income

Part 2 Major Exceptional Expenses

Gross Salary and Wages _____
 Child Support _____
 Retirement _____
 Social Security _____
 Rental-Lease Income _____
 Other Income _____
Total Income _____

Major Medical _____
 Child Care _____
 Adult Care _____
 Other _____
Total Expenses _____

Number of Family Members Income Supports: _____

Acknowledgement

I have been informed of my reduced fee and understand that I am responsible for paying any balance that I accrue. I understand this reduced fee is a scholarship that is based on current financial information given to the Center at the time of intake. **If at any time my financial situation changes, I will inform the Center and supply updated information to be used in the determination of a new fee arrangement.** I further understand that if I have accrued a credit balance at the time of service termination, those additional monies on my account will be applied to reimburse the Samaritan Center for any scholarship funds that I have received.

I am waiving my right to use insurance, including Medicare and Medicaid, and I understand the Samaritan Center will not be billing insurance for any services provided.

Printed Name: _____ Signature: _____ Date: _____

SCCPC Staff Signature _____ Date _____

<u>To Be Completed By Samaritan Staff</u>	
Adjusted Annual Income _____	Agreed Upon Fee _____
Copy of Income Documentation Verified and Collected by (staff initials) _____	
Treating Therapist _____	
Approval/signature of Executive Director or Clinical Director for all insurance or payroll subsidies: _____	
Name	Title



PRIVACY PRACTICES ACKNOWLEDGEMENT

Please Print Client Name _____

Please read and complete ONE form for each couple and/or family.

I have reviewed the *Notice of Privacy Practices* and understand and acknowledge that:

- SCCPC's *Notice of Privacy Practices* is posted in the waiting room where I can view it at any time, and I may request a copy of the notice at any time. The notice is also posted on the website: www.samaritan-center.org.
- If I have any questions about the notice, I should ask my therapist, or SCCPC's Privacy Officer, for clarification
- SCCPC may change or modify its *Notice of Privacy Practices* at any time and I have the right to obtain a revised *Notice of Privacy Practices* by accessing www.samaritan-center.org, calling the office and requesting a revised copy be mailed to me, or asking for one at the time of my next appointment.

I understand that State and/or Federal laws permit or require the use or disclosure of my Health Information without my consent or authorization in the following circumstances:

- **Child Abuse:** If we have reason to believe that a child has been, or may be abused, neglected, or sexually abused, we must make a report within 48 hours to the Texas Department of Protective and Regulatory Services.
- **Adult Abuse:** If we have reason to believe that an elderly or disabled person has been or may be abused, neglected, or exploited, we must immediately report this to the Texas Department of Protective and Regulatory Services.
- **Serious Threat to Health or Safety:** If we determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, we may disclose relevant confidential mental health information to medical or law enforcement personnel.
- **Judicial or Administrative Proceedings:** We can share health information about you in response to a court or administrative order.

Each ADULT Participant in Counseling must sign below (only one form is needed for each couple and/or family):

_____	_____	_____
Counseling Participant or Legal Representative	Date	Description of legal representative's authority
_____	_____	_____
Counseling Participant or Legal Representative	Date	Description of legal representative's authority
_____	_____	_____
Counseling Participant or Legal Representative	Date	Description of legal representative's authority
_____	_____	_____
Counseling Participant or Legal Representative	Date	Description of legal representative's authority

If counseling participant is a minor:

_____	_____
Print Minor's Name	Print Minor's Name
_____	_____
Print Minor's Name	Print Minor's Name
_____	_____
Signature of Parent, Guardian or Legal Representative	Description of legal representative's authority
_____	_____
SCCPC Staff Signature	Date

PERSONAL HISTORY QUESTIONNAIRE

Name: _____ Your Age _____ Today's Date _____

Reason (s) for seeking counseling _____

Who suggested that you seek counseling? _____ Relationship to you _____

What do you hope to accomplish? _____

Counseling History: Current Past - when and why? _____

With whom? _____ If past, did you accomplish your goals? Yes No

What type of counseling? : Individual Couples Family Substance abuse Group Other _____

SPIRITUALITY: Whom do you go to for support in time of need? God spouse family friends other

nobody. How important are spiritual values to you? Very much Somewhat Not at all. Do you use prayer or meditation to help you through life struggles? Yes No Are you actively involved with a group that enhances your spiritual values? _____ Do you feel connected with others in the group? _____ Would you like to use spirituality as part of your therapy? Yes No, I do not want to.

MEDICAL HISTORY

I would rate my current physical health as Excellent Good Fair Poor Very Poor

I am under the care of a psychiatrist Family doctor A Specialist Acupuncturist Herbalist

I am being treated for _____

Name of Doctor(s): _____

Date of Last Doctor's Visit: _____ Date of Last Physical Exam: _____

Medications: Yes No - Current Prescriptions and over-the-counter: (Include doses) _____

Please list any *major* illnesses, injuries, health problems you have had over the years _____

Have you ever been hospitalized for mental health issues? No Yes -when? _____

Have you ever attempted suicide? No Yes - if yes, how many times and when? _____

I have recently noticed increased negative changes in the following areas (check all that apply):

1. In my everyday life: Sleeping Concentration Appetite Alcohol or drug abuse Energy level Anxiety Depression Stress Optimism Sex drive Relationships Moods Anger Negative Thoughts self-doubts Faith issues feeling disconnected from others other _____

2. At work : Performance Concentration Attendance Co-worker conflicts Supervisor conflicts

Easily frustrated Getting angry Under Pressure Distraction Making more mistakes

3. Others have expressed concerns about me, because: _____

Employment and education: Employed / Self-employed: Company? _____ How long? _____

Are you satisfied? Yes No Seeking Work Retired Disabled FT Homemaker

Education: (circle last year completed) 4 5 6 7 8 9 10 11 12 College/Tech 1 2 3 4 Graduate: 1 2 3 Degree _____

RELATIONSHIP AND FAMILY HISTORY (choose more than one if necessary)

Single (never married) Married, how long? _____ Divorced, how long? _____ Separated, how long? _____

Engaged committed relationship Widowed Other _____

Length of current relationship before marriage/Living together: _____. How many previous marriages? _____

Give age and gender of your children: _____

How many are under your care? _____ Custody: Full Shared

Do you have any custody issues pending? _____ Do you have any conflicts with an ex-spouse/Partner?

How many adult children do you have? _____ What kind of relationship do you have with them? _____



Samaritan Center for Counseling and Pastoral Care Healthcare Coordination Form

Client Name: _____ Date of Birth _____

Client: Research indicates there is a close relationship between physical and mental health and that better treatment outcomes will be achieved if your therapist and your primary care physician coordinate your care. Many physical complaints are rooted in psychosocial issues and physical symptoms can be signs of mental stress. This coordination and consultation is especially important if you are on medication. Medication may have side effects that could affect your mood, ability to concentrate and fully participate in therapy. This form is to give your consent to consult with your psychiatrist, primary care physician, nurse practitioner, or other providers to ensure you receive the best possible care from the Samaritan Center. Most insurance companies require coordination of care with all appropriate behavioral health and medical providers.

Please check one:

____ I give permission for you to coordinate my care with my other healthcare providers

____ I do not have a Primary Care Physician or see any other doctors at this time

____ I do not give permission for consultation with other providers at this time

Physician Name: _____ Clinic Name: _____

Telephone: _____ Fax number: _____

Physician Name: _____ Clinic Name: _____

Telephone: _____ Fax Number: _____

Physician Name: _____ Clinic Name: _____

Telephone: _____ Fax Number: _____

Client (or guardian) signature Date

Therapist signature Date Therapist name printed

PHYSICIAN/PROVIDER: You have been identified as this client’s medical provider. We want to inform you that your patient was seen for outpatient psychotherapy at the Samaritan Center and has authorized us to consult with you as necessary regarding their treatment. **Please feel free to contact us if you would like additional information.**

Please acknowledge below that this client is a patient of yours and that you will be available for consult.

- 1. ____ We have no record of having provided recent medical care to the client.
- 2. ____ This is our patient and we will be available for consult if needed.

Comments/Medication:

Physician’s signature (or official representative) Date

Please Return by fax: 512-451-8729 Or mail to:

Samaritan Center for Counseling and Pastoral Care, 8956 Research Blvd., Bldg 2, Austin, TX 78758 (www.samaritan-center.org)

For Samaritan Center Office Use Only: Date faxed to Physician _____ initials _____

Express Payments and Missed Appointment Charges

As a courtesy to you, we try to make reminder calls for most appointments; however, it is your responsibility to remember your appointment times. If you are unable to make your appointment, you must call to cancel and/or reschedule at least 24 hours in advance. Please understand your appointment has been reserved just for you. If we don't receive adequate notice to fill your allotted time, we cannot give another person the same opportunity to receive services. Failure to give 24-hr notice will result in a cancellation charge equal to your session fee. If you use insurance to pay for counseling, the session fee includes your copay and the amount we receive from your insurance or EAP. If you pay privately, the full session fee is what you normally pay for a session. In no case will the charge be less than \$20. The cancellation charge will be applied whether or not you receive a reminder call. If you have questions about this policy, please discuss with your therapist. Thank you.

Card type: _____ Visa _____ MasterCard _____ American Express _____ Discover _____

Card number: _____

Expiration date (month/year): _____

3 digit security code on back of card: _____

Billing zip code: _____

Name as printed on card: _____

I understand my credit card will be kept on file and charged when I fail to cancel an appointment 24 hours in advance.

Client Signature

Date

Express Payment Option

The Samaritan Center can keep your credit card on file and automatically charge it for each appointment. Please indicate below if you would like this Express Service.

_____ I would like the Samaritan Center to run my credit card each time I receive treatment and services, for my convenience.

Client signature

Date