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.

<u>Your Rights as a Client.</u>
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: <u>If an appointment is missed or canceled with less than 24 hours notice, you will be charged for that session.</u> 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). <u>If you miss an appointment two weeks in a row or twice in one month, you will lose your recurring appointment time</u>. 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 CEOs 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 ___________

(Complete one for each child)

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: _________

PERSONAL INFORMATION FORM Date____________

(Complete one for each adult that might accompany child)

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 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	________________	Major Medical	__________________
Retirement	________________	Child Care	_________________
Social Security	________________	Adult Care	_________________
Rental-Lease Income	________________	Other	_________________
Other Income	________________		
Total Income	________________	**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 ______________________

To Be Completed By Samaritan Staff

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

SAMARITAN CENTER
The Path to Wellness™

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 Date Description of legal representative's authority

____

SCCPC Staff Signature Date

SAMARITAN CENTER
The Path to Wellness

AGREEMENT & CONSENT FOR TREATMENT FORM

Please Print Client Name: ________________________________

Please read and complete one of these forms for each couple and/or family.

I have read and understood the information contained in the *Information About Center Services* document. In signing this *Client Agreement and Consent for Treatment Form*, I acknowledge that:

- I do hereby consent to treatment by The Samaritan Center for Counseling and Pastoral Care.
- I voluntarily enter into therapy with the therapist whose name is listed below.
- I may withdraw from treatment at any time unless treatment is court ordered.
- I am 18 years of age or over and have not been declared incompetent by a court of law, or
- I am the parent/legally-appointed guardian or other authorized representative of the client to be treated, if such client is 17 or younger, or
- Although under 18 years of age, I am legally empowered to consent to treatment per the conditions outlined in the Texas Family Code.
- I acknowledge that I am financially responsible to the Center as described in the Client Information Form for all services and treatment rendered to the client named in this consent.
- I have received a copy of my rights as a client in the State of Texas included in *Information About Center Services.*

I further acknowledge the following:

- I understand that therapy is a joint endeavor between the therapist and client, the results of which cannot be guaranteed. Progress depends on many factors, including motivation, effort, and life circumstances.
- If my therapist believes that counseling is not appropriate for my circumstances or that I should be referred elsewhere, I will be so informed.
- I understand that effective counseling involves my attending regularly-scheduled counseling appointments and talking openly with my counselor.
- My therapist will inform me of any possible risks in my seeking therapy and will work with me in determining the best course of treatment.
- I understand my right to have any tests, procedures, and recommendations explained to me in simple terms. I have the right to refuse such tests, procedures, or recommendations.
- I have been informed that my therapist is a ☐ Staff Therapist ☐ Therapist in Training.

I acknowledge that the information contained in the Agreement and Consent for Treatment Form has been made available to me, explained to me, or read by me and that it was presented in clear non-technical language. My signature affirms that the information is understood by me and enables me to make an informed voluntary consent to this treatment.

Each ADULT Participant in Counseling must sign below (only one signature page 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: I give permission for the following minor child(ren) to receive therapy and to receive therapy without a parent or guardian present.

____________________ ____________________
Print Minor's Name Print Minor's Name

____________________ ____________________
Print Minor's Name Print Minor's Name

____ ____________________
Signature of Parent, Guardian or Legal Representative Date Description of legal representative's authority

____
SCCPC Staff Signature Date

CHILD/ADOLESCENT
PERSONAL HISTORY QUESTIONNAIRE

Child/Youth Name: ______________________________ Age _____Today's Date ________________

MEDICAL

Is your child/adolescent currently under a doctor's care? (check one or more) No ☐ psychiatrist ☐ family physician ☐ other ☐

Name of Doctor(s): ____

For what illness(s) are they being treated? ____

Current Medications (prescriptions and over-the-counter): ______________________________________

Any Known Allergies:____

Date of Last Doctor's Visit: ______________ Date of Last Physical Exam: ____________Status of Health: ______________________

Allergies: ____

Indicate recent changes in (check all that apply): weight ☐ appetite ☐ sleeping patterns ☐ mood ☐

Please list any ***major*** illnesses, injuries, health problems they have had: ______________________________________

____

If they have had previous counseling or psychiatric care, please indicate when (approximate) and with whom: ___________________

____

EDUCATION LEVEL: _______________ **SCHOOL CURRENTLY ATTENDING:** ____________________________________

Extracurricular activities: ____

FEELINGS CHECKLIST: Please check each term below which describes your child's current or recent feelings.

- ☐ Angry
- ☐ Energetic
- ☐ Ambitious
- ☐ Sad
- ☐ Anxious
- ☐ Isolated
- ☐ Fearful
- ☐ Depressed
- ☐ Happy
- ☐ Violent
- ☐ Hopeless
- ☐ Confused
- ☐ Dangerous
- ☐ Inadequate
- ☐ Outgoing
- ☐ Lonely
- ☐ Irritable
- ☐ Bereaved
- ☐ Guilty
- ☐ Ashamed
- ☐ Fatigued
- ☐ Suicidal
- ☐ Unhappy
- ☐ Optimistic
- ☐ Distrustful
- ☐ Apathetic
- ☐ Hurt
- ☐ Numb
- ☐ Abused
- ☐ Sleep difficulties
- ☐ Puzzling ideas
- ☐ Resentful
- ☐ Hopeful
- ☐ Jealous
- ☐ Indifferent
- ☐ Work stress
- ☐ Loss of meaning
- ☐ Loss of self respect
- ☐ Cheerful
- ☐ Loss of love
- ☐ Loss of control
- ☐ Overeating
- ☐ Drug use
- ☐ Alcohol use
- ☐ Fretful
- ☐ Unwelcome thoughts
- ☐ Loss of appetite
- ☐ Worried
- ☐ Panic

YOUR CHILD'S FAMILY

Person's Name	Age or Year If Deceased	Marital Status	Education	Occupation	Quality of Relationship	Mental/Physical Illness
Mother:						
Father:						
Step-Mother:						
Step-Father:						
Other Primary Care Giver(s):						
Siblings:						

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 #: ______________________________

Physician Name: ________________________________ Clinic Name: _____________________________________

Telephone: ___________________ Fax #:______________________________

Physician Name: ________________________________ Clinic Name: _____________________________________

Telephone: ___________________ Fax #: ______________________________

____

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

<u>Please Return by fax:</u> 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