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. If you are a veteran, active service member, spouse, surviving spouse, or child of a veteran or active service member (including, of course, step-children, and foster children), please let us know. We have many resources and discounted services for military families through our Hope for Heroes program.

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 professional counselors, licensed social workers, licensed marriage and family therapists. We also have advanced 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.

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, e-mail, or by not showing up. Periodically during therapy, you will 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*, and you may request a copy. 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 (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: Please 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.

Appointments and Cancellations: If an appointment is missed or cancelled 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 may schedule someone else in that appointment time. This charge is not covered by insurance. If you use insurance, you will be charged a $50 cancellation fee for a missed appointment or late cancellation. If you are paying privately, you will be charged the fee you normally pay for a counseling session **(minimum charge of $20 and maximum of $50 for a missed appointment or late cancellation).** If you miss an appointment two weeks in a row or twice in one month, you may 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.

Email Policy: We cannot ensure the confidentiality of information shared over email. Email is not a recommended form of communication with a therapist or staff member at Samaritan Center.

Emergencies: If you are a current client and have an urgent concern, we will schedule an appointment with your counselor or an available therapist as quickly as possible. If you are experiencing a life-threatening emergency and need mental health support after business hours, please contact either 9-1-1 or the National Suicide Hotline at 1-800-273-8255. If you are experiencing a non-life-threatening emergency that cannot wait until the next business day, please contact the Samaritan Center on-call staff at 512-656-5517 (please note that this is a wireless phone and therefore is not a secure line). After-hours messages can be left on the Center's voice-mail system at 512-451-7337, 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 Complaints: To make a complaint against a counselor, you may fill out a written complaint form with the Texas Department of State Health Services. For more information, please visit www.dshs.texas.gov/plc/plc_complain.shtm or call 1-800-942-5540.

Responsible person's signature: I have been informed of the Samaritan Center Policies and Procedures:

Signature of Counseling Participant or Legal Representative: _____ Date: _____

Name (Printed): _____

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_____/_____/_____ Gender: □ Male □ Female

Address_____City_____State_____Zip_____

County: □Travis □Williamson □Hays □ Other _____

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

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

Are you a military: □ N/A □ Service Member □ Veteran □ Spouse, surviving spouse, child □ Other (Describe below)

Relationship to Veteran or Service Member: _____

*PLEASE provide documentation to prove military status such as DD214 or MILITARY ID, etc. to qualify for our HOPE FOR HEROES programs and discounts

Contact Info:

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 □ Letter? □ Email ? Email Address_____

Who may we contact on your behalf in case of emergency: Name_____ Phone #_____

If applicable, an alternative mailing address for billing statements:

Address _____City _____State _____Zip_____

INSURANCE Information:

Primary Insurance:_____ Member ID _____Group # _____

Policy Holder Name:_____ Policy Holder Date of Birth _____

Is this a Medicare plan? _____ (yes or no)

Secondary Insurance:_____ Member ID _____Group # _____

Policy Holder Name:_____ Policy Holder Date of Birth _____

Is this a Medicare plan?_____ (yes or no)

Will someone other than person receiving services be responsible for payments? □ **Yes** □ **No** If Yes, complete the following:

(This section required for minors)

First Name_____ Last Name_____ Phone# _____

Address_____City_____State_____Zip_____

Organization (if applicable):_____

Responsible person's signature - Insured or privately paying client: 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: _____

SAMARITAN CENTER SCHOLARSHIP APPLICATION

Name: _____ Date: _____

The Samaritan Center strives to offer affordable services for all individuals, regardless of their financial situation. In order to provide affordable treatment, we offer a scholarship program for individuals with a significant financial need. To determine your eligibility, please complete this form and return it to the main office with proof of 30 days' worth of most recent income or your most recent tax return. *If you are awarded a scholarship, we will ask for ongoing documentation to verify income* ***every six months or as income/household information changes***.

PLEASE COMPLETE ALL FIELDS:

Service requesting: ☐Counseling ☐ Acupuncture ☐ Telepsychiatry

Number of people living in **household**: _____ Combined monthly **household** income: _____

Part 1: Monthly Household Income (all sources for all members in household)	**Part 2: Unusual Monthly Expenses (does not include everyday living expenses)**
Gross Salary and Wages:	Major Medical Debt Payments (if making monthly payments):
Child Support Income:	Child Care:
Retirement:	Adult Care:
Social Security or other benefits:	Other:
Rental Lease Income:	
Other Income:	
Total Income:	**Total Unusual Expenses:**

Acknowledgement:

I have been informed of the scholarship procedures and understand that I am responsible for paying any balance that I accrue. I understand that a 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 understand that I am financially responsible for the cost of missed appointments or cancellations with less than a 24 hours' notice. 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.

Client's Signature: _____ SCCPC Staff Signature: _____

To Be Completed By Staff:

Adjusted Annual Income: _____ Agreed Upon Fee: _____

Copy of Income Documentation Verified and Collected by (staff initials): _____

Extenuating Circumstances: _____

_____

_____

Approval/signature of officer manager: _____

Printed Name: _____ Date: _____

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CANCELLATION AND NO SHOW POLICY

If it is necessary to cancel your scheduled appointment, **we require that you call at minimum 24 hours in advance of your appointment.** Your early cancellation will give another client the opportunity to receive services. A failure to present at the time of a scheduled appointment or cancel within 24 hours will be recorded as a **"Cancel or No Show Charge"** and the fee will be billed to your account.

If you use insurance, you will be charged a $50 cancellation fee for a missed appointment or late cancellation, which is not covered by insurance. If you are paying privately, you will be charged the fee you normally pay for a counseling session (minimum charge of $20 and maximum of $50 for a missed appointment or late cancellation).

While we understand that situations may arise, as a nonprofit organization, it is our goal to prevent no-shows that deter our timely care to *all* clients, therefore, **sickness without documentation may not be a valid excuse for cancelling without a 24-hour notice.**

We thank you in advance for your cooperation and understanding.

I acknowledge the Samaritan Center's cancellation and no-show policy.

(Sign) _____/(Print) _____ Date:___/___/___

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AGREEMENT & CONSENT FOR TREATMENT FORM

By signing below, I do hereby voluntarily consent to be treated with acupuncture and/or substances from the Oriental Materia Medica by a licensed acupuncturist at Integrative Medicine at the Samaritan Center. I understand that acupuncturists practicing in the state of Texas are not primary care providers and that regular primary care by a licensed physician is an important choice that is strongly recommended by this clinic's practitioners.

Acupuncture/Moxibustion: I understand that acupuncture is performed by the insertion of needles through the skin or moxibustion by the application of heat to the skin (or both) at certain points on or near the surface of the body in an attempt to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I am aware that certain adverse side effects may result. These could include, but are not limited to: local bruising, minor bleeding, fainting, pain or discomfort, the possible aggravation of symptoms existing prior to acupuncture treatment, and pnuemothorax. I understand that no guarantees concerning its use and effects are given to me and that I am free to stop acupuncture treatment at any time.

Direct Moxibustion: I understand that if I receive direct moxibustion as part of therapy, there is a risk of burning or scarring from its use. I understand that I may refuse this therapy.

Chinese Herbs: I understand that substances from the Oriental Materia Medica may be recommended to me to treat bodily dysfunction or diseases, to modify or prevent pain perception, and to normalize the body's physiological functions. I understand that I am not required to take these substances but must follow the directions for administration and dosage if I do decide to take them. I am aware that certain adverse side effects may result from taking these substances. These could include, but are not limited to: changes in bowel movement, abdominal pain or discomfort, and the possible aggravation of symptoms existing prior to herbal treatment. Should I experience any problems, which I associate with these substances, I should suspend taking them and call Integrative Medicine as soon as possible.

Cupping: I understand that if I receive cupping as a part of therapy, there is a risk of burning, bruising, minor bleeding, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this therapy.

Acupressure/Asian Bodywork Therapy (ABT): I understand that I may also be given acupressure or ABT as part of my treatment to modify or prevent pain perception and to normalize the body's physiological functions. I am aware that certain adverse side effects may result from this treatment. These could include, but are not limited to: bruising, sore muscles or aches, and the possible aggravation of symptoms existing prior to treatment. I understand that I may stop the treatment if it is too uncomfortable.

Electro-Acupuncture: I understand that I may be asked to have electro-acupuncture administered with the acupuncture. I am aware that certain adverse side effects may result. These may include, but are not limited to: electrical shock, pain or discomfort, and the possible aggravation of symptoms existing prior to treatment. I understand that I may refuse this treatment.

*I understand that there may be other treatment alternatives, including treatment offered by a licensed physician.

*I acknowledge that my acupuncturist has the right to refuse services if I am under the influence of drugs or alcohol, to include misuse of prescription drugs.

I have carefully read and understand all of the above information and am fully aware of what I am signing. I understand that I may ask my practitioner for a more detailed explanation. I give my permission and consent to treatment.

Signature: _____ Date: _____

Printed Name: _____ Date of Birth: _____

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PRIVACY PRACTICES ACKNOWLEDGEMENT

Please Print Client Name_____

Please read and complete ONE form for each person participating in session.

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:

_____ _____

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

_____ _____

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

_____

SCCPC Staff Signature Date

MEDICAL EVALUATION

In the state of Texas, acupuncture and Oriental medicine is not considered "primary health care".
As a result Integrative Medicine at Samaritan Counseling Center is required to have you respond to the following statements before you are treated. Please be advised that we will not be permitted to treat you with acupuncture if your response to ***all*** *of these statements is "No".*

I have been evaluated by a physician or dentist for the condition being treated within the last twelve months.

Yes No

OR

I have received a referral from my chiropractor within the last 30 days for acupuncture. After being referred by a chiropractor, if after two months or 20 treatments, whichever comes first, no substantial improvement occurs in the condition being treated, I understand that the acupuncturist is required to refer me to a physician. (It is my responsibility and choice whether to follow this advice.)

Yes No

OR

I have not been evaluated by a physician or dentist for the condition being treated, nor have I received a referral from a chiropractor, but I seek treatment for symptoms related to one or more of the following conditions:

___ Chronic pain
___ Smoking addiction
___ Weight loss
___ Alcoholism
___ Substance abuse

Permission to maintain medical privacy and share medical information

All of the information that you provide to us is strictly confidential. It is our policy never to disclose any personal or medical information about any patients under our care without first obtaining your express permission to do so. There are, however, a few instances where we feel that sharing information about your case helps to provide the best possible clinical outcome. In an effort to maximize your clinical results, we may want to contact your counselor, physician, dentist, or chiropractor and send them periodic updates about your case and your progress. Do you grant your permission for us to discuss the details of your case with your Doctor(s)?

Yes No

Name of Doctor, dentist or chiropractor _____

I have completed this form correctly to the best of my knowledge.

Patient Name OR Name of Parent/Guardian: _____

Signature: _____ Date : _____

INTEGRATIVE MEDICINE QUESTIONNAIRE

Please help us provide you with a complete evaluation by taking the time to fill out this confidential health questionnaire carefully.

Full name _____ Sex F M Date of Birth _____

E-mail Address _____ Allow email contact by Samaritan Center? Yes No

How did you hear about the Samaritan Center's Integrative Medicine services? _____

Integrative Medicine treatments are on a sliding scale based on income and number of household members. Based on this information I agree to pay the rate of $_____ per acupuncture treatment. If an acupuncture treatment is missed, or less than 24 hours notice is given for a cancelation, I understand I will be charged **$35** for the missed treatment. Patient Initials: _____

Please list your main health concerns, causes (if known) and approximate dates they began in order of priority.

1. _____ _____
2. _____ _____
3. _____ _____

What diagnoses have you received for your concerns? _____

Do these problems interfere with your daily activities (work, sleep, sex, etc.)? _____

What kinds of treatment have you tried? _____

What helps? _____ _____

What makes the problem(s) worse? _____

Is there anybody in your family with the same/similar problems? _____ _____

Medical History (Please include the month/year when the event occurred or when the diagnosis was established)

DIAGNOSIS	SELF	FAMILY	DIAGNOSIS	SELF	FAMILY
Cancer (what type)			**Venereal Disease**		
Breathing problems			**Emotional Disorders**		
Tuberculosis			**Seizures**		
Hepatitis			**Alcoholism**		
Digestive Disorders			**Anemia**		
High Blood Pressure			**Arthritis**		
Thyroid Disease			**Depression or Anxiety**		
OTHER					

Significant traumas (incl. year): (auto accidents, sports injuries, etc.): _____

_____

Surgeries (incl. year): _____

_____

Hospitalizations (incl. year): _____

_____

Allergies: (drugs, chemicals, foods, environmental):_____

_____

Please provide a complete list of all medications taken within the last two months, including vitamins, OTC drugs, herbs, etc:

_____

_____

_____

_____

How many hours do you sleep in general? _____What time do you usually go to bed? _____

How much coffee do you drink? _____cups/day Colas _____number/day Tea _____cups/day

What kind of alcoholic beverages do you usually drink, if any? _____Average # of drinks/week? _____

How much water do you drink per day? _____

Are you a vegetarian? Yes No Yes, but not so strict. Do you eat a lot of spicy food? Yes No

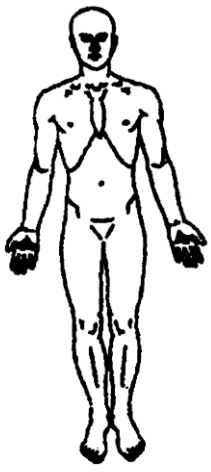
Remarks and additional information (re: diet) _____

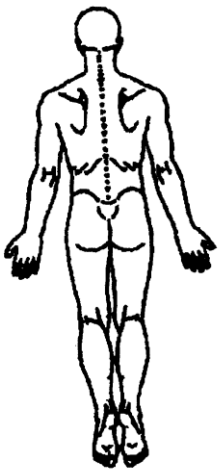
If you are a smoker, # of cigarettes per day _____How long have you been smoking? _____

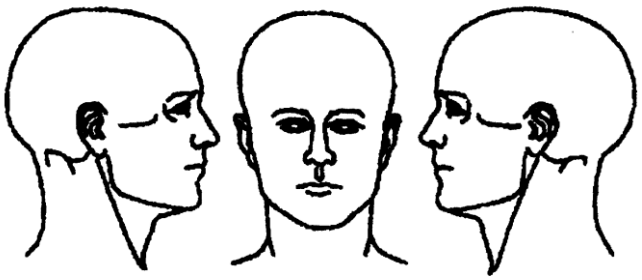
Do you want to quit? Yes No (Level of determination to quit – 1 2 3 4 5 6 7 8 9 10)

Indicate pain or discomfort with:

Sharp • Dull X Tingle ::: Burn Δ Cramp + Numb = Cold O







Please check if you have or have had (in the last three months) any of the following diseases or conditions.

Musculoskeletal □ Neck tightness □ Neck pain □ Shoulder pain □ Hand/wrist pain □ Elbow pain □ Back pain □ Hip pain □ Knee pain □ Pain/soreness in the muscles □ Muscle weakness □ Joint disorders □ Tremors □ Cold hands/feet □ Swelling of hands/feet □ Hernia □ Numbness □ Tingling □ Paralysis □ Joint sprain □ Difficulty walking □ Spinal curvature: □ Cervical □ Thoracic □ Lumbar □ Other? _____

General □ Poor appetite □ Poor sleep □ Sleep apnea □ Fatigue □ Sensitive to cold □ Sensitive to heat □ Night sweats □ Sweat easily
□ Tremors □ Cravings □ Change in appetite □ Bleed or bruise easily □ Weight loss □ Weight gain □ Desire hot food
□ Desire cold food □ Strong thirst (cold or hot drinks) □ Sudden energy drop (What time of day) _____
Favorite time of year _____ Worst time of year _____

Neuro-psychological □ Traumatic Brain Injury (mTBI, TBI) □ Loss of balance □ Lack of coordination □ Concussion □ Poor memory
□ Poor concentration □ Difficulty making decisions □ Speech problem □ Depression □ Anxiety □ Stress □ Short temper
□ Mood swings □ Other; any formal diagnoses? _____

Head, eyes, ears, nose, and throat □ Dizziness □ Concussions □ Migraines □ Glasses/lens □ Eye strain □ Eye pain
□ Color blindness □ Night blindness □ Poor vision □ Cataracts □ Blurry vision □ Earaches □ Ringing in ears □ Poor hearing
□ Spots in front of eyes □ Sinus problems □ Nose bleeding □ Sore throat □ Grinding teeth □ Teeth problems □ Facial pain
□ Jaw pain □ Sores on lips/tongue □ Difficulty swallowing □ Other? _____

Skin & hair □ Rashes □ Ulcerations □ Hives □ Itching □ Eczema □ Pimples □ Acne □ Dandruff □ Dry skin □ Recent moles
□ Loss of hair □ Change in hair or skin texture □ Other?_____

Cardiovascular □ High blood pressure □ Low blood pressure □ Chest pain □ Palpitation □ Fainting □ Phlebitis □ Irregular heartbeat
□ Rapid heartbeat □ Varicose veins □ Other? _____

Respiratory □ Cough □ Coughing blood □ Shortness of Breath □ Wheezing □ Difficulty breathing □ Bronchitis □ Pneumonia
□ Chest pain/tightness/congestion □ Production of phlegm – color? _____

Gastrointestinal □ Nausea □ Vomiting □ Diarrhea □ Constipation □ Gas □ Bloating □ Belching □ Black stools □ Blood in stools
□ Indigestion □ Bad breath □ Rectal pain □ Hemorrhoids □ Abdominal pain/cramps □ Gallbladder problems □ Parasites
□ Bowel incontinence □ Chronic laxative use Bowel movements: Frequency _____ Consistency (Formed/Loose?) _____

Genito-urinary □ Painful urination □ Frequent urination, day/night □ Blood in urine □ Urgency to urinate □ Kidney stones
□ Unable to hold urine □ Dribbling □ Pause of flow □ Frequent UTI □ Genital pain □ Genital itching □ Genital rashes □ STD
□ Other _____

Female □ Frequent vaginal infections □ Pelvic infection □ Endometriosis □ Vaginal/genital discharge □ Fibroids □ Ovarian cysts
□ Regular periods □ Clots □ Pain/cramps prior/during periods □ Breast tenderness □ Breast lumps □ Fertility issues
□ Hot flashes □ Moodiness related to periods □ Hysterectomy/ovaries removed
First date of last period _____ Age of first period _____ Duration of periods _____days, Cycle ____ days
Number of pregnancies _____ Number of births _____ Miscarriages _____ Abortions _____ C-section _____
Do you practice birth control? □ Yes □ No If yes, what type and for how long? _____
If you're on birth control pills, what are you taking and for how long? _____

Male □ Prostate problems □ Discharge □ Erectile dysfunction □ Ejaculation problems □ Frequent seminal emission

□ Fertility problems □ Painful/swollen testicles □ Other _____

Please sign below to confirm you have completed this form correctly and to the best of your knowledge.

□ Adult Patient □ Parent or Guardian □ Spouse

_____ _____

Signature **Date**

Please write in any additional health concerns you would like to discuss today.

SAMARITAN CENTER
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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. *We encourage you to allow us to coordinate care with your medical 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

_____I give permission for you to coordinate my care with my other healthcare providers - If selected you must provide the following:

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: *NOTE: THIS IS NOT A REQUEST FOR MEDICAL RECORDS* 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, call 512-451-7337 if questions, 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 _____