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, stepchildren, 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 (LPC), Licensed Clinical Social Workers (LCSW), and Licensed Marriage and Family Therapists (LMFT). We also employ Licensed Masters Social Workers (LMSWs) working toward advanced licensure as well as pre-graduate master level interns completing their final practicum before graduation. 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: In addition to accepting most major health insurances, we also offer private pay. An initial counseling session fee is $150 and ongoing sessions are $125 for a 53+-minute session. If you cannot afford the regular fee, the Center may adjust your fee considering your income and number of family members. Proper documentation is required. We can provide a superbill if you wish to see a provider that does not accept your insurance. Payment of your agreed upon fee is due at the time of your appointment unless prior arrangements have been made. We accept cash, check or credit card.

Returned Checks: A $30 fee is charged on all checks returned for non-sufficient funds.

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 are in our Hope for Heroes Program, there is a $25 fee for late cancellations or missed appointments.** 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.** All cancellations fees must be paid upon your next visit. If you miss an appointment two weeks in a row or twice in one month, you may lose your recurring appointment time. If you miss or cancel three visits, we reserve the right to terminate services. 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, including custody evaluations. However, if you choose to subpoena your therapist, you agree to pay for any required preparation time, for your therapist's time out of the office, and for travel at **a charge of $300 per hour.**

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 during business hours, we will schedule an appointment with your counselor or an available therapist as quickly as possible. **If you are experiencing a life-threatening emergency or you or a loved one are at immediate risk of harming yourself or someone else, call 9-1-1 or got to your nearest emergency room.** Talk to your therapist if you believe you will need additional support after business hours.

Local emergency mental health resources (available 24 hours a day) are as follows:

National Suicide Hotline/Veteran Crisis Line:	1-800-273-8255.
Travis County Crisis Line:	512-472-HELP (4357)
Hays County Emergency Crisis Line:	1-877-466-0660
Williamson County Crisis Line:	1-800-841-1255

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 child/parent.

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**: _____

Do you have children ages 0-24 living at home or whom you financially support? □ Yes □ No

Have you or a family member ever served in the military? ☐ N/A ☐ Active Duty ☐ Veteran ☐ Spouse of a service member/veteran, surviving spouse ☐ Child of a service member/veteran
Branch of Service: ☐ Air Force ☐ Army ☐ Coast Guard ☐ Marine Corps ☐ Navy ☐ National Guard ☐ Reserves

***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: _____

Personal Information Form

Date_____

Please complete all information requested. Complete one form for each child/parent.

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**: _____

Do you have children ages 0-24 living at home or whom you financially support? ☐ Yes ☐ No

Have you or a family member ever served in the military? ☐ N/A ☐ Active Duty ☐ Veteran ☐ Spouse of a service member/veteran, surviving spouse ☐ Child of a service member/veteran
Branch of Service: ☐ Air Force ☐ Army ☐ Coast Guard ☐ Marine Corps ☐ Navy ☐ National Guard ☐ Reserves

***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

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 your most recent proof of income (for anyone that receives income in your household). This will be either 30 days' worth of paycheck stubs, benefits/award letter or your most recent tax return, if it still reflects your current income**. *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

Family/Household Members (Please list all members in your household) and age for each person	**Relationship (i.e. self, spouse, dependent, other)**	**Annual GROSS Income (before taxes) for each member. If none – please indicate.**	**Source of income (i.e. wages, SSA benefits, unemployment, etc.)**	**Please list any expenses/reasons that are currently causing financial stress (outside of everyday expenses)**
Total Family/Household Size:		**Total Household 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 (unless applying for a subsidy).

Client's Signature: _____ Name: _____ Date: _____

To Be Completed by Staff (if applicable):

Adjusted Annual Income: _____ Agreed Upon Fee: _____

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

Extenuating Circumstances: _____

_____

Staff approval/signature: _____

Printed Name: _____ Date: _____

SAMARITAN CENTER

The Path to Wellness

PRIVACY PRACTICES ACKNOWLEDGEMENT

Please Print Client Name_____

Please read and complete ONE form for each person participating in session (Couples may share one form).

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

SAMARITAN CENTER

The Path to Wellness

AGREEMENT & CONSENT FOR TREATMENT FORM

Please Print Client Name: _____

Please read and complete ONE form for each person participating in session (Couples may share one form).

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

_____ _____

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

Child & Adolescent Therapy Policies

As a community mental health clinic, our responsibility and goal are the well-being of our clients. In the case of a child as the primary client, it is essential that parents and/or legal guardians are in an agreement as to the decision to treat, the treatment goals, appointment times and the need to maintain client confidentiality, in accordance with their legal rights and any court-ordered custody documentation. As a result, it is the policy of the Samaritan Center that all minors presented for treatment have the following authorization and consent on file.

Please check box most appropriate:

☐ **1. Both Legal Parents/Guardians Consent to Treatment**

- Both legal parents/guardians agree to the treatment and providing of mental health services for their child and will indicate their consent below.

- If the biological or legally adopted parents are currently separated or going through the divorce process, both parents are still required to sign a Consent for Mental Health Treatment Form before the child can be treated.

☐ **2. Independent or Exclusive Right to Consent:**

- There is an official certified divorce decree or a legal custody order that indicates that only one parent is legally permitted to determine and decide on mental health treatment of the child without the consent of other parent (In this case, please provide us with a copy of this legal document in its entirety).

☐ **3. Missing or Deceased Parent**

- The parent presenting the child for treatment has no access to other parent due to the following reasons (death, in prison, missing, has left and made no contact, etc...) and therefore will affirm that they are the sole primary care taker of the child for mental health treatment, have the legal authority to provide and will bear all responsibility for such consent.

☐ **4. Parent on Military Deployment**

- When a parent is on military deployment, a Family Care Plan and/or Power of Attorney form that outlines a custodial parent's right to consent for treatment will be accepted in lieu of the deployed parent's written consent. Notarized Statements (see below) may also be used. Where possible, the SC therapist will attempt to contact the deployed parent/guardian and document said attempts.

***PLEASE NOTE: If you checked box # 2, 3 or 4, there will be an additional form to sign upon check-in for initial appointment.**

Name of Parent #1: _____

Signature: _____ Date: ____/_____/____

Name of Parent #2: _____

Signature: _____ Date: ____/_____/____

Therapist Signature: _____ Date: ____/_____/____

THERAPIST INVOLVEMENT IN CONFLICT AND/OR COURT PROCEEDINGS

The therapeutic process is a team approach, especially in the case of a minor child. The following informed consent states that each parent, and/or any legal guardian with legal authority to make health care decisions of the child, will agree to these terms and communicate effectively with each other as well as with the providers involved to create a supportive and conducive environment for treatment.
Although our responsibility to your child may require our involvement in conflicts between parents and guardians, you agree that our involvement will be strictly limited to that which will benefit your child. This means, that you each agree as a condition of us treating your child that:

- If you choose to begin legal proceedings of any kind (including but not limited to divorce and custody disputes, work-related injuries, lawsuits, etc.), you agree that neither you, your attorneys or anyone acting on your behalf will subpoena records from your provider's office or subpoena your provider to testify in court or in any legal proceeding. By your signature below, you specifically agree to abide by this condition of treatment.

- Our role is limited to providing treatment and the provider will not provide custody evaluations or recommendations or legal advice, as these activities are not within the scope of the provider's practice.

- You understand that in the event that a provider is subpoenaed to provide records or testimony in violation of this agreement, The Samaritan Center reserves the right to terminate the professional, therapeutic relationship immediately and refer you to other mental health providers.

- If there is a court appointed evaluator, and if appropriate authorization forms are signed, or a court order authorizing disclosure of treatment records is sent to us, we will disclose the requested treatment and general information about the minor, but we will not make any recommendations concerning the child's custody or custody arrangements, unless otherwise ordered by a court.

- In the event that a provider is subpoenaed to provide records or testimony in violation of this agreement, you acknowledge and agree you will pay for all of the provider's professional time, including preparation and transportation costs, even if the provider is called to testify by another party. For providing services in any legal matter, the provider's hourly fee is $300 per hour. The provider will charge this rate for preparation time related to any legal proceeding, travel time from the provider's office to the location of the proceeding, and all time spent in attendance at any legal proceeding. No refunds will be given within one week of the court date if the hearing is cancelled or rescheduled, since counseling appointments with other clients would have been cancelled or rescheduled to accommodate the court appearance.

Name of Parent #1: _____

Signature: _____ Date: ____/_____/____

Name of Parent #2: _____

Signature: _____ Date: ____/_____/____

Therapist Signature: _____ Date: ____/_____/____

AUTHORIZATION FOR PARENTS IN THE EVENT OF DIVORCE OR COURT PROCEEDINGS

I, _____, _____ of
Parent/Guardian Name Relationship to child

_____ hereby authorize, with the total understanding of the above-mentioned terms and conditions, my child(ren) to receive mental health treatment at the Samaritan Center and assume all financial responsibility for their treatment.

- I have provided the clinic with a certified or legal copy of the divorce or custody decree (if applicable) that indicates that I have full authority to make any and all decisions regarding my child's mental health treatment.

- I understand that it is ultimately my responsibility to make sure that I am following all legal conditions set forth by my divorce decree, separation agreements, etc.

- I acknowledge that the Samaritan Center is requesting any and all related documents for the benefit of my child and therefore release any liability to the Samaritan Center, any of its providers, office staff, and/or affiliates resulting from a dispute to this authorization.

- I affirm that I have the authority to make health care decisions for my child(ren) and am aware that all custodial parents and legal guardians must give consent before treatment begins.

- I understand that the Samaritan Center requires **the consent of both parent/legal guardians of the child in order to release any clinical records.**

- I understand and agree that any breach of these agreements may result in the termination of any, and all, of my (or my child(ren)'s relationship(s) with The Clinic or any of its providers, affiliates, and/or staff members. I have been given the opportunity to ask any questions I may have had and am voluntarily signing this agreement.

- I understand and agree that in the event that a provider is subpoenaed to provide records or testimony in violation of this agreement, I will pay for all of the provider's professional time, including preparation and transportation costs, even if the provider is called to testify by another party. I have been informed that:
    - For providing services in any legal matter, the provider's hourly fee is $300 per hour.
    - The provider will charge this rate for preparation time related to any legal proceeding, travel time from the provider's office to the location of the proceeding, and all time spent in attendance at any legal proceeding.
    - No refunds will be given within one week of the court date if the hearing is cancelled or rescheduled, since counseling appointments with other clients would have been cancelled or rescheduled to accommodate the court appearance.

Name of Parent #1: _____

Signature: _____ Date: ____/_____/____

Name of Parent #2: _____

Signature: _____ Date: ____/_____/___

CHILD / ADOLESCENT PERSONAL HISTORY QUESTIONNAIRE

Please use additional paper if needed.

Child's/Adolescent's Name: _____ DOB: _____ Age _____ Today's Date: _____

MEDICAL

Is your child/adolescent currently under a doctor's care? □ Yes □ No (If yes, check all that apply):
□ Psychiatrist □ Family physician □ Other

Name of Doctor(s):_____

Any Known Allergies: _____

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

Indicate recent changes (check all that apply): □ Weight □ Appetite □ Sleeping patterns □ Mood

Please list any **major** illnesses, injuries, surgeries, or health problems your child has had:

_____

□ Yes □ No - Has your child ever had to be **hospitalized** for medical *or* psychiatric reasons? If yes, please explain.

_____

Current medications **and dosage** (prescriptions and over the counter): _____

_____

□ Yes □ No - Has your child had previous counseling or psychiatric care? If yes, please indicate type, when (approximate), and with whom: _____

_____

□ Yes □ No To your knowledge, is your child sexually active?

□ Yes □ No Do you feel comfortable discussing issues of sex/sexuality with your child?

Please describe your child's social support network (check all that apply):
□ Family □ Neighbors □ Friends □ Religious/Spiritual Center □ Support/Self-Help Group
□ Community Group □ Other: _____

What does your family do for fun?_____

EDUCATION INFORMATION

CURRENT GRADE LEVEL: _____ SCHOOL CURRENTLY ATTENDING: _____

This year's school grades:	□ Excellent	□ Good	□ Fair	□ Poor
Past school grades:	□ Excellent	□ Good	□ Fair	□ Poor
This year's school behavior:	□ Excellent	□ Good	□ Fair	□ Poor
Past school behavior:	□ Excellent	□ Good	□ Fair	□ Poor

Has your child had any of the following difficulties at school?

□ Suspension	□ Incomplete homework	□ Learning difficulties	□ Referrals or detentions
□ Poor grades	□ Getting teased or picked on (Including cyber bullying)	□ Speech problems	□ Attendance problems

□ Yes □ No - Has your child ever repeated or skipped a grade? If yes, please explain. _____

_____

□ Yes □ No - Has your child ever received Special Education services or accommodations at school (including 504, IEP)? If yes, please describe. _____

_____

What are some of your child's strengths/skills/talents? _____

_____

SYMPTOM CHECKLIST:
Below is a list of symptoms some children may experience. Please check all your child's behaviors and symptoms that you consider problematic:

□ Easily distracted
□ Hyperactivity
□ Irritability
□ Impulsivity
□ Poor memory/concentratio
□ No/few friends
□ Poor social skills
□ Nightmares

□ Peer/sibling conflict
□ Sexual behavior
□ Aggression
□ Defiance
□ Stealing
□ Lying
□ Destroys property
□ Sets fires

□ Toileting problems
□ Panic attacks
□ Sadness/depression
□ Wide mood swings
□ Anxiety/worry
□ Low self-esteem
□ Seeing/hearing things that aren't there
□ Obsessions or compulsions

□ Computer/gaming addiction
□ Alcohol/drug use
□ Overeating/hoarding food
□ Restricting food intake
□ Frequent headaches or stomachaches

Other Concerns:

_____

□ Yes □ No - Has your child ever had thoughts, made statements, or attempted to hurt him/herself? If yes, please describe: _____

_____

□ Yes □ No - Has your child ever had thoughts, made statements, or attempted to hurt someone else? If yes, please describe: _____

_____

Approximately how many hours a day does your child have screen time (television, computer/video games, internet, or smartphone)?

_____

FAMILY AND DEVELOPMENT HISTORY

□ Yes □ No - Were there any medical problems during the pregnancy or birth of your child? If yes, please describe:

_____

□ Yes □ No - Did the biological mother use any tobacco, medication, street drugs, or alcohol while pregnant with this child? If yes, please describe substances used, quantity, and frequency (if known): _____

_____

□ Yes □ No - Did your child have any developmental delays in early childhood (crawling, walking, talking, toileting, etc.)? If yes, please describe: _____

_____

YOUR CHILD'S FAMILY

□ Parents legally married or living together □ Parents temporarily separated □ Parents divorced or permanently separated

Relationship	Name	Age or Year if Deceased	Lives with Child?	Education Level	Occupation	Quality of Relationship
Mother						
Father						
Stepmother						
Stepfather						
Other Primary Caregiver(s)						
Siblings						

LEGAL INFORMATION

If child's parents are separated or divorced, what is the current child custody/visitation arrangement?

_____

_____

□ Yes □ No - Is your child currently the subject of a custody case?

□ Yes □ No - Does your child have any legal offenses on record or pending in the courts? If yes, please describe.

_____

STRESSORS
Below is a list of stressors that your child may have experienced. Understanding what has happened in your child's life helps us form a more effective treatment plan for your child and family.

Please check all that apply:

- ☐ Natural disaster
- ☐ Medical trauma (such as chronic illness or surgery/medical procedure)
- ☐ Frequent moves (from homes/schools)
- ☐ Time in foster care
- ☐ Separation from parent or caregiver
- ☐ Grief/loss of a loved one
- ☐ Witnessing a caregiver under influence of drugs/alcohol
- ☐ Domestic violence in the home
- ☐ Substance abuse in the home
- ☐ Victim of physical abuse
- ☐ Victim of physical/emotional neglect
- ☐ Victim of sexual abuse
- ☐ Victim of verbal/emotional abuse
- ☐ Perpetrator of abuse
- ☐ Vehicle accident
- ☐ Victim of a crime
- ☐ Refugee/war zone
- ☐ Community/school violence or bullying
- ☐ Victim of kidnapping
- ☐ Parental separation/divorce
- ☐ Poverty

☐ **Yes** ☐ **No** Has Child Protective Services ever been involved in your child's life? *If yes*, please provide time frame and any services received below:

_____

_____

_____

Samaritan Center for Counseling and Pastoral Care
Healthcare Coordination Form

SAMARITAN CENTER
The Path to Wellness

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 _____