SAMARTIAN COUNSELING CENTER

CHILD AND ADOLESCENT INITIAL INFORMATION

Therapist _____
File No. _____
(For office use only)

Please fill out this form as completely as you can. All information is confidential.

Date: _____

Name of person completing this form: _____

Child's Name: _____

Birth Date: _____ Age: _____ Sex: M _____ F _____

School:_____Grade: ____ Teacher's Name: _____

Physician: _____ Phone: _____

Child's Resides: With both parents _____ With mother _____ With father _____

Other _____

Child's Ethnicity: _____ White/Anglo _____ Asian/Pacific Islander _____ Black/African American
_____ Hispanic _____ Native American _____ Other

Mother's Name: _____ DOB: _____

Address: _____City: _____ State: _____

Zip: _____ County: _____ Employer: _____

Telephone:_____ _____ _____
(Home) (Work) (Cell)

Father's Name: _____ DOB: _____

Address: _____City: _____State: _____

Zip: _____ County: _____ Employer: _____

Telephone:_____ _____ _____
(Home) (Work) (Cell)

Emergency Contact: _____ _____ _____ _____
(Required) (Name) (Relationship) (Home Phone) (Cell Phone)

Religious Preference(s): _____Congregation(s) Attended: _____

Who Referred You To The Samaritan Counseling Center?

_____ Clergy _____ Doctor ____ Internet _____Family/Friend _____ Attorney/Court _____ Insurance
_____ School _____ Former Client _____ Media _____ Other - _____
(Please Specify)

Payment Responsibility:

- ❑ Insurance Provider: _____
  Policy Holder: _____
  Member/Suscriber#:_____
- ❑ Self Pay
- ❑ Bill to third party: _____
  (name/address)

If the child's legal guardian is someone other than one or both parents, identify that person:

Name: _____

Address: _____

Telephone(s): _____

Parents' Marital Status:

___Married ___Single ___Divorced ___Spouse Deceased ___Separated

If Divorced, Spouse Deceased, or Separated, how old was the child when this occurred: _____

If Divorced, Who Has Legal Custody?

_____Mother _____Father _____Joint _____Other

Step Parent's Name: (if applicable): _____

Siblings:

Name	**Age**
_____	_____
_____	_____
_____	_____
_____	_____

Has Your Child Had Previous Therapy? Yes _____ No _____

If Yes, with whom? _____ When? _____

Is Your Child Currently Taking Any Medications? Yes _____ No _____

Medication(s): _____

For what?: _____

Prescribed by: _____

Length of time on medication: _____

Please State Briefly The Concerns That Bring Your Child To Counseling:

_____

_____

_____

_____

Please Check The Items Below That Describe Or Relate To The Concerns Mentioned Above:

Eating problems		Sad, tearful	
Soiling of clothing, bedding		Loss of interest or pleasure in activities	
Wetting of clothing, bedding		Feeling worthless, guilty	
Sleep problems		Suicidal thoughts	
Bad dreams, nightmares		Suicidal behavior	
Sleepwalking		Self-harm	
Under active		Mood swings	
Overactive		Panic attacks	
Speech problems		Afraid	
Vocal tics		Worries	
Selectively mute		Separation anxiety	
Stuttering		Aggressive	
Hair pulling		Anger	
Motor tics		Irritable	
Odd, erratic, disorganized behavior		Argues	
Compulsive, repetitive behavior		Defiant	
Vague physical complaints		Drop in grades	
Pain		Behavior problems at school	
Preoccupied with being sick		Problems with other children	
Fakes being sick		Problems with teachers	
Body image problems		Relationship problems with parents	
Sexual problems		Drug use	
Gender confusion		Alcohol use	
Hears things that others do not		Breaks rules	
Sees things that other do not		Stealing	
Odd beliefs		Property destruction	
Obsessive thoughts		Fire starting	
Memory problems		Gambling	
Easily distracted		Cursing	
Impulsive		Lying	

Would you like to receive Samaritan Counseling Center's Bi-annual Newsletter _____Yes _____No

Email_____

SAMARITAN COUNSELING CENTER

DEVELOPMENTAL HISTORY FORM

PLEASE COMPLETE THIS FORM. NOTE THAT IT IS DOUBLE SIDED. IF YOU HAVE ANY QUESTIONS, PLEASE ASK YOUR CHILD'S THERAPIST.

Person completing this form		Date

Child's Name		File #

Child was adopted	Yes	No
If adopted, at what age		
If adopted, with any siblings (please list their ages)		

DURING PREGNANCY, THE CHILD'S MOTHER EXPERIENCED

Severe stress	Yes	No
Mental health problems	Yes	No
Physical illness	Yes	No
Physical injury	Yes	No
Prescription medication use	Yes	No
Caffeine use	Yes	No
Nicotine use	Yes	No
Alcohol use	Yes	No
Did the child's father use alcohol prior to conception?	Yes	No
Drug use	Yes	No

DURING LABOR AND DELIVERY

There were signs of fetal distress during pregnancy	Yes	No
The child was carried to full term	Yes	No
There were signs of fetal distress during labor or delivery	Yes	No
There were complications during delivery	Yes	No

Number of hours from initial labor pains to birth	
Child's birth weight	
Mother's age when child was born	

IMMEIDATELY AFTER BIRTH AND OVER THE NEXT FEW DAYS, THE CHILD

Had trouble breathing	Yes	No
Had an infection	Yes	No
Had seizures	Yes	No
Was given medications	Yes	No
Was found to have a congenital birth defect	Yes	No
Was in the hospital for several days	Yes	No

AT ANY TIME DURING THE FIRST 12 MONTHS, WAS THE CHILD

Difficult to feed	Yes	No
Difficult to get to sleep	Yes	No
Colicky	Yes	No
Difficult to put on a schedule	Yes	No
Alert	Yes	No
Cheerful	Yes	No
Affectionate	Yes	No
Sociable	Yes	No
Easy to comfort	Yes	No
Difficult to keep busy	Yes	No
Very active	Yes	No
Very stubborn	Yes	No

AT WHAT AGE DID THE CHILD

Sit without help	

Crawl		
Walk without help		
Talk with one or two words		
Talk in sentences of several words		
Start and finish learning to use the toilet for urination		
Start and finish learning to use the toilet for defecation		
The overall toilet training process could be described as		
Since mastery of the toilet, has child wet or soiled the bed or clothing	Yes	No
Since mastery of the toilet, has child played with or smeared feces	Yes	No

AT ABOUT 1 YEAR OF AGE, HOW DID THE CHILD TYPICALLY RESPOND TO SEPARATIONS FROM THE PRIMARY CARE-TAKER

Separated easily with no distress	Yes	No
Was hesitant and somewhat clingy but separated without obvious distress	Yes	No
Was somewhat resistant and clingy, even tearful, but easily consoled	Yes	No
Was very resistant, clingy, and upset and not easily consoled	Yes	No
Behaved in odd, unusual, inconsistent ways	Yes	No

AT ABOUT 1 YEAR OF AGE, HOW DID THE CHILD TYPICALLY RESPOND TO REUNIONS WITH THE PRIMARY CARE-TAKER

Approached the care-giver in an obviously positive manner	Yes	No
Actively avoided the care-giver	Yes	No
Unsure of whether to approach or avoid the care-giver	Yes	No
Behaved in odd, unusual, inconsistent ways	Yes	No

DID THE CHILD HAVE ANY SEPARATION OR REUNION PROBLEMS AT THE FOLLOWING TIMES

When first starting day care or preschool	Yes	No
When first starting kindergarten	Yes	No
When first starting 1st grade	Yes	No

SPEAKING GENERALY ABOUT THE CHILD'S PERSONALITY

In response to a new situation, the child typically	Approaches		Avoids
The child typically prefers	The company of others		Solitude
The child's energy level is typically	Low	Normal	High
The child tries to bother care-givers on purpose	Yes	No	

HAS THE CHILD EXPERIENCED

More than one daycare or preschool setting	Yes	No
If yes, how many daycare or preschool settings		
Long-term separations from a family member	Yes	No
Death of a family member	Yes	No
Neglect	Yes	No
Verbal abuse	Yes	No
Physical abuse	Yes	No
Sexual abuse	Yes	No
A serious accident	Yes	No
Any other traumatic experience	Yes	No
If so, what		

HAS THE CHILD WITNESSED

Domestic violence	Yes	No
Criminal activity	Yes	No
A serious accident	Yes	No
Any other traumatic event	Yes	No
If so, what		

IN SCHOOL, HAS THE CHILD

Had learning problems	Yes	No
Received Special education services	Yes	No
Refused to go to school	Yes	No
Had problems following the teacher's directions	Yes	No
Had problems getting along with the other students	Yes	No
Been held back or retained	Yes	No

HAS THE CHILD HAD ANY OF THE FOLOWING HEALTH PROBLEMS

Serious illness	Never	Past	Present
Serious injury	Never	Past	Present
Hospitalization	Never	Past	Present
Surgery	Never	Past	Present
Head injury with loss of consciousness	Never	Past	Present
Asthma	Never	Past	Present
Allergies	Never	Past	Present
Diabetes	Never	Past	Present
Epilepsy	Never	Past	Present
Seizures	Never	Past	Present
Heart problems	Never	Past	Present
High Fevers	Never	Past	Present
Lead poisoning	Never	Past	Present
Speech or language problems	Never	Past	Present
Chronic ear infections	Never	Past	Present
Hearing difficulties	Never	Past	Present
Vision problems	Never	Past	Present
Fine motor problems	Never	Past	Present
Gross motor problems	Never	Past	Present

Appetite problems	Never	Past	Present
Sleep problems	Never	Past	Present
Medication induced problem	Never	Past	Present
Alcohol induced problem	Never	Past	Present
Drug induced problem	Never	Past	Present
Other medical problems			

LIST THE CHILD'S BLOOD RELATIONS THAT HAVE HAD ANY OF THE FOLLOWING MENTAL HEALTH PROBLEMS

Problem	Family member(s)
Autism	
Anxiety	
ADHD	
Alcoholism	
Depression	
Drug abuse	
Eating disorder	
Learning disabilities	
Mental retardation	
Unusual behavior	
Unusual thinking	
Suicide	

Additional comments

Name_____
File # _____

SAMARITAN
COUNSELING
CENTER

NEW MEXICO NOTICE FORM

Notice of Therapists' Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

The Samaritan Counseling Center (The Center) may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
  – *Treatment* is when The Center provides, coordinates or manages your health care and other services related to your health care. An example of treatment would be when your therapist consults with another health care provider, such as your family physician or another psychologist.
  - *Payment* is when The Center obtains reimbursement for your healthcare. Examples of payment are when The Center discloses your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within The Center such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of The Center, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

The Center may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when your therapist is asked for information for purposes outside of treatment, payment and health care operations, The Center will obtain an authorization from you before releasing this information. The Center will also need to obtain an authorization before releasing your psychotherapy notes. "*Psychotherapy notes*" are notes your therapist has made about your conversation during a private, group, joint, or family counseling session, which have been kept separate from the rest of your psychological record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) The Center has relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

The Center may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** In certain circumstances, your therapist is required to report child abuse in a variety of forms, including neglect, to (1) a local law enforcement agency; (2) the office of the Department of Child, Youth and Family Services in the county where the child resides; or (3) tribal law enforcement or social services agencies for any Indian child residing in Indian country.

- **Adult and Domestic Abuse:** If your therapist has reasonable cause to believe that an incapacitated adult is being abused, neglected or exploited, they must immediately report that information to the Department of Child, Youth and Family Services.

- **Health Oversight:** If the New Mexico Board of Psychology is conducting an investigation, The Center is required to disclose your mental health records upon receipt of a subpoena from the Board.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and The Center may not release information without written authorization from you or your personal or legally-appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.

- **Serious Threat to Health or Safety:** When your therapist judges that a disclosure of confidential information is necessary to protect against a substantial and imminent risk that you

will inflict serious harm on yourself or another person, your therapist has a duty to report this information to the appropriate people who would address such a risk (for example, the police or the potential victim).

- **Worker's Compensation:** When a claim is filed, your therapist is required by law to release those records that are directly related to any injuries or disabilities claimed by you (for which you are receiving benefits from your employer) to you, your employer, your employer's insurer, a peer review organization or the health care selection board.

IV. Patient's Rights and Therapist's Duties

Patient's Rights:

- *Right to Request Restrictions* -- You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, The Center is not required to agree to a restriction you request.

- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are being seen at The Center. Upon your request, The Center will send your bills to another address.)

- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in The Center's mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. The Center may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, The Center will discuss with you the details of the request and denial process.

- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. The Center may deny your request. On your request, The Center will discuss with you the details of the amendment process.

- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, The Center will discuss with you the details of the accounting process.

- *Right to a Paper Copy* – You have the right to obtain a paper copy of the Notice from The Center upon request, even if you have agreed to receive the notice electronically.

Therapist's Duties:

- The Center is required by law to maintain the privacy of PHI and to provide you with a notice of The Center's legal duties and privacy practices with respect to PHI.
- The Center reserves the right to change the privacy policies and practices described in this notice. Unless The Center notifies you of such changes, however, The Center is required to abide by the terms currently in effect.
- If The Center revises their policies and procedures, The Center will mail you a revised notice. A copy will also be posted in the office.

V. Complaints

If you are concerned that The Center has violated your privacy rights, or you disagree with a decision The Center made about access to your records, you may contact Dr. Sarah Brennan or Arlene Harmon at (505) 842-5300.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 14, 2003.

The Center reserves the right to change the terms of this notice and to make the new notice provisions effective for all PHI that The Center maintains. The Center will provide you with a revised notice by mail.

_____ _____

Client Signature Date

_____

Parent or Guardian Signature
if client in under 18

_____

Relation to client

Name _____
File # _____

PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT

Welcome to The Samaritan Counseling Center. This document (the Agreement) contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI). HIPAA requires that The Center provide you with a Notice of Privacy Practices (the Notice) for use and disclosure of PHI for treatment, payment and health care operations. The Notice, which is attached to this Agreement, explains HIPAA and its application to your personal health information in greater detail. The law requires that The Center obtain your signature acknowledging that you have been provided this information. Although these documents are long and sometimes complex, it is very important that you read them carefully, and we can discuss any questions you may have. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on the therapist unless The Center has taken action in reliance on it; if there are obligations imposed on The Center by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and patient, and the particular problems you are experiencing. There are many different methods your therapist may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. It calls for a very active effort on your part.

Psychotherapy can have benefits and risks. Since therapy often involves discussing difficult aspects of your life, you may experience uncomfortable feelings. On the other hand, psychotherapy has also been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

Our first few sessions will involve an evaluation of your needs. By the end of the evaluation, your therapist will be able to offer you some first impressions of what the work will include and a treatment plan to follow, if you decide to continue with therapy. You should evaluate this information along with your own opinions of whether you feel comfortable working with your therapist. Therapy involves a commitment of time, money, and energy, so you should be very careful about the therapist you select. If you have questions about your therapist's procedures, you should discuss them whenever they arise. If your doubts persist, The Center will help you set up a meeting with another mental health professional for a second opinion, if you wish.

MEETINGS

The Center normally conducts an assessment that will last from 1 to 3 sessions. During this time, we can both decide if your therapist is the best person to provide the services you need in order to meet your treatment needs. If psychotherapy is begun, your therapist will generally schedule one 45-minute session per week at a time agreed upon, although some sessions may be longer or more frequent.

PROFESSIONAL FEES

The fee for professional services at the Center is $120.00, including counseling appointments, report writing, telephone conversations, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other service you may request of the Center. If you become involved in legal proceedings that require your therapist's participation, you will be expected to pay for that professional time, including preparation and transportation time. The Center charges $240.00 per hour for attendance at any legal proceeding. The fee for initial sessions at the Center is $180.00. The Center for Changing Families requires a $25 non-refundable registration fee from each party prior to the scheduling of appointments in that program.

Once an appointment is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation. Insurance companies do not provide reimbursement for cancelled sessions.

CONTACTING YOUR THERAPIST

Due to the work schedule, your therapist may not be immediately available by telephone. He/she will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please inform your therapist of some times when you will be available. In after-hours emergencies, you may page the therapist on call by following the directions on the voice mail message at 842-5300. If you are unable to reach your therapist and feel that you can't wait for a return call, contact your family physician or the nearest emergency room and ask for the therapist on call. If your therapist will be unavailable for an extended time, he/she may provide you with the name of a colleague to contact, if necessary.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a mental health professional. In most situations, The Center can only release information about your treatment to others if you sign an Authorization form that meets certain legal requirements. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- The Center may occasionally find it helpful to consult other health and mental health professionals. During a consultation, The Center makes every effort to avoid revealing the identity of our patients. The other professionals are also legally bound to keep the information confidential. If you don't object, your therapist will not tell you about these consultations unless they feel that it is important to your work together. The therapist will note all consultations in your chart.

- You should be aware that The Center practices with other mental health professionals and employs administrative staff. In most cases, your therapist may need to share protected information with these individuals for clinical or administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. **All staff members have received special training on how to protect your privacy and have sworn not to release any information outside of the practice without the permission of a professional staff member.**

- The Center may also have contracts with business associates, such as bookkeepers and accountants. As required by HIPAA, The Center has formal business associate contracts with these businesses in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, The Center can provide you with the names of these organizations and/or a blank copy of this contract.

- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

There are some situations in which The Center is permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the therapist-patient privilege law. Your therapist cannot provide any information without your (or your personal or legally-appointed representative's) written authorization, or a court order. **If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order your therapist to disclose information.**

- If a government agency is requesting the information for health oversight activities, The Center may be required to provide it for them.

- If a patient files a complaint or lawsuit against the therapist, The Center may disclose relevant information regarding that patient in order to defend the therapist and/or The Center.

There are some situations in which The Center is **legally obligated** to take action. **When a therapist determines it is necessary to attempt to protect a patient or others from harm, The Center may have to reveal some information about a patient's treatment.** These situations are uncommon in The Center's practice.

- **If your therapist knows or has reasonable cause to believe that a child under 18 is an abused or a neglected child, the law requires that your therapist immediately report the matter to an appropriate governmental agency, usually the Child, Youth and Family Department in the county where the child resides. Once such a report is filed, The Center may be required to provide additional information.**

- **If your therapist has reasonable cause to believe that an incapacitated adult is being abused, neglected or exploited, The Center must immediately report that information to Adult Protective Services. Once such a report is filed, The Center may be required to provide additional information.**

- **If The Center believes that a patient presents a substantial and imminent risk of serious harm to another, The Center may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.**

- **If a patient threatens a substantial risk or serious harm to himself/herself, The Center may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection**

If such a situation arises, The Center will make every effort to fully discuss it with you before taking any action and The Center **will limit their disclosure to what is necessary.**

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that you discuss any questions or concerns that you may have now or in the future with your therapist. The laws governing confidentiality can be complex, and we are not attorneys. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

The laws and standards of our profession require that The Center keep Protected Health Information (PHI) about you in your Clinical Record. Except in unusual circumstances that involve danger to yourself and/or others or where information has been supplied to the therapist confidentially by others, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, The Center recommends that you initially review them in the presence of your therapist, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, The Center is allowed to charge a copying fee of $.25 per page (and for certain other expenses). If The Center refuses your request for access to your records, you have a right of review, which your therapist will discuss with you upon request.

PATIENT RIGHTS

HIPAA provides you with several rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that The Center amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and The Center's privacy policies and procedures. Your therapist will be happy to discuss any of these rights with you.

MINORS & PARENTS

In the case of minor children, signing this Agreement provides authorization to treat my child. Patients 14 years of age and older have the right to consent to and receive individual psychotherapy and information about that treatment cannot be

disclosed to anyone without the child's agreement. Parents have the right to review the records of children under 14 unless the therapist decides that such access is likely to injure the child, or you and the therapist agree otherwise. Since parental involvement in therapy is important, it is the policy of The Center to request an agreement between a minor-aged patient 14 to 18 years old and his/her parents, allowing the therapist to share general information about the progress of the child's treatment and his/her attendance at scheduled sessions. Any other communication will require the child's Authorization, unless the therapist feels that the child is in danger or is a danger to someone else, in which case the therapist will notify the parents of that concern. Before giving parents any information, the therapist will discuss the matter with the child, if possible, and do his/her best to handle any objections he/she may have.

BILLING AND PAYMENTS

You will be expected to pay for each session at the time it is held, unless your therapist agrees otherwise or unless you have insurance coverage that requires another arrangement. Payment schedules for other professional services will be agreed to when they are requested. In circumstances of unusual financial hardship, The Center may be willing to negotiate a fee adjustment or payment installment plan.

For returned checks we assess a $4.00 insufficient fund charge. If your account has not been paid for more than 120 days and arrangements for payment have not been agreed upon, The Center has the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require the disclosure of otherwise confidential information. In most collection situations, the only information The Center releases regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. The Center will fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; **however, you (not your insurance company) are responsible for full payment of fees**. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. The Center will provide you with whatever information we can based on our experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, The Center is willing to call the company on your behalf.

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. **These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning**. It may be necessary to seek approval for more therapy after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel they need more services after insurance benefits end. You and your therapist may discuss the options you have under such circumstances.

You should also be aware that your contract with your health insurance company requires that your therapist provide it with information relevant to the services that are provided to you. **The therapist is required to provide a clinical diagnosis**. Sometimes the therapist is required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, The Center will make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, The Center has no control over what they do with it once it is in their hands. The Center will provide you with a copy of any report we submit, if you request it. By signing this Agreement, you agree that the therapist can provide requested information to your insurance carrier.

"I hereby authorize the release of medical information to my insurance company. If insurance claims are filed through this office, I authorize medical benefits for those services to be paid to this office."

Once we have all of the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your therapy. It is important to remember that you always have the right to pay for services yourself to avoid the problems described above unless prohibited by contract.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

_____ _____

Client Signature Date

_____ _____

Parent or guardian signature if client is under 18 Date

_____

Relation to client

SAMARITAN
COUNSELING
CENTER

Missed Appointments and Late Cancellation Policy

- I understand that if I miss a scheduled appointment, or cancel less than 24 hours before the appointment, I am responsible for paying the cost of the appointment.

- I understand that if I miss an appointment, or do not cancel with 24 hour notice, which involves another party with whom I am sharing the cost, I am responsible for the total cost of the appointment.

- I understand that Samaritan Counseling Center is not able to bill my insurance for missed appointments and that I may be charged for the cost of that appointment.

- I understand that supplemented fee amounts are based upon gross household income from all sources.

Print Name: _____

Signature: _____

Date: _____

SAMARITAN COUNSELING CENTER

FEE AGREEMENT FOR ADDITIONAL PROFESSIONAL TIME
Child & Adolescent Form

Patient Name: _____ File #: _____

There are several services beyond conducting therapy that your child's therapist might have to provide. These tasks are important to serving your child's best interests and include, but are not limited to:

- Telephone consultations with other professionals involved either currently or in the past. For example: school staff (counselor, teacher), medical professionals (psychiatrist, pediatrician), other mental health providers (custody evaluator, family therapist), or legal professionals (guardian ad litem, attorney).
- In-person consultations with other professionals, including transportation time.
- Telephone consultations with parents (beyond routine matters).
- Preparing documents such as letters and reports to parents or other professionals.
- Reviewing legal, educational, or past treatment records.
- Other non-routine services specific to a given child. To the extent reasonably possible, these individualized tasks will be identified ahead of time and reviewed prior to carrying out and billing for them.

Because these services require professional time, there is a fee for which you will be charged. Insurance typically does not cover these costs so you will be personally responsible for payment. Billing will be based on 15 minute units of time and prorated based on the Center's hourly fee of $120.00 (15 minutes would cost $30.00; 30 minutes, $60.00; etc.). If these tasks are performed in preparation for or attendance at legal proceedings, the Center's hourly fee is $150.00.

_____ _____

Signature (legal guardian for patients under 18 years old) Date