

Therapist _____

File No. _____
(For office use only)

SAMARITAN CENTER FOR CHANGING FAMILIES

The information asked for below is to help us understand you and your concerns. Please fill out this form as completely as you can.

DATE: _____

NAME: _____
(FIRST) (MIDDLE) (LAST)

ADDRESS: _____

(CITY) (STATE) (ZIP) (COUNTY)

TELEPHONE: _____
(HOME) (WORK) (CELL)

AT WHICH PHONE NUMBER DO YOU PREFER TO RECEIVE CALLS? : _____

BIRTH DATE: _____ AGE: _____ SEX: _____

ETHNICITY: _____ White/Anglo _____ Asian/Pacific Islander _____ Black/African American
_____ Hispanic _____ Native American _____ Other

EMERGENCY CONTACT (Name & Phone Number) _____
(required)

CURRENT MARITAL STATUS: _____ MARRIED _____ SINGLE _____ WIDOWED
_____ DIVORCED _____ SEPARATED _____ RE-MARRIED _____ NEVER MARRIED

IF CURRENTLY MARRIED, DATE OF CURRENT MARRIAGE: _____
(Month/Day/Year)

CURRENT SPOUSE'S NAME: _____

NAME OF OTHER PARENT OR OTHER PARTY (ex-partner): _____

RELATIONSHIP TO CHILD (if not other parent): _____

PREVIOUS MARRIAGES (dates, how terminated): _____

WHO HAS LEGAL CUSTODY? _____ JOINT _____ MOTHER _____ FATHER _____ OTHER

CHILD RESIDES: WITH BOTH PARENTS _____ WITH MOTHER _____ WITH FATHER _____

CHILDREN: OTHER (please specify): _____
NAME AGE

STEP CHILDREN: _____
(if any) _____

ANY CHILDREN DECEASED? YES NO IF YES, WHEN? _____

CAUSE OF DEATH: _____

CHILD'S NAME AND AGE AT TIME OF DEATH: _____ (Name) _____ (Age)

IS THERE A HISTORY OF FAMILY TRAUMA OR LOSS? (If yes, please explain): _____

EDUCATION / OCCUPATION

YOUR EDUCATION (indicate last grade completed/last degree earned): _____

YOUR OCCUPATION: _____

MEDICAL CONDITIONS

DO YOU PRESENTLY TAKE ANY MEDICATIONS? _____ IF YES, WHAT? _____

FOR WHAT CONDITIONS? _____ PRESCRIBED BY: _____

LENGTH OF TIME ON MEDICATION: _____

DO YOU HAVE ANY PROBLEMS WITH SUBSTANCE ABUSE? _____

ARE YOU PRESENTLY RECEIVING THERAPY? _____ IF YES, WITH WHOM? _____

HAVE YOU HAD PREVIOUS THERAPY? _____ IF YES, WHEN AND WITH WHOM? _____

WHO REFERRED YOU TO THE SAMARITAN CENTER FOR CHANGING FAMILIES?: _____

IS THERE A COURT ORDER? NO _____ YES _____ (IF YES, PLEASE ATTACH)

WHO IS THE JUDGE IN YOUR CASE? _____

DO YOU HAVE AN ATTORNEY? YES _____ NO _____ NAME: _____

DO YOU HAVE PENDING COURT DATES? _____
(Trial, hearing, court clinic appointments, other court business)

CONCERNS:

- | | | |
|---|---|---|
| <input type="checkbox"/> Child's adjustment to divorce/separation | <input type="checkbox"/> Blended family/step-parent issues | <input type="checkbox"/> Co-parenting Issues |
| <input type="checkbox"/> Relationship with Child's other parent | <input type="checkbox"/> Relationship with your own parents | <input type="checkbox"/> Relationship with children |
| <input type="checkbox"/> Marriage/Relationship | <input type="checkbox"/> Confusion | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Substance abuse (alcohol or drugs) | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Anger |
| <input type="checkbox"/> Other | | |

STATE IN YOUR OWN WORDS THE CONCERNS THAT BRING YOU TO THE SAMARITAN CENTER FOR CHANGING FAMILIES:

SPECIFIC CONCERNS ABOUT CHILDREN: _____

OTHER: _____

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:

Therapist:

Client Name(s): _____

File#: _____

**Samaritan Center for Changing Families
Fee Agreement for Additional Professional Time**

Samaritan Center for Changing Families (SCCF) provides the following services:

- Wiseparent co-parenting and communication counseling, therapeutic mediation
- Therapeutic reintroduction and reintegration between parents and their children.

The fee for services is \$120 per hour. Payment is due at the time of service. SCCF services may not meet criteria for reimbursement from health insurances; however, other services may be reimbursable. Examples of services NOT payable by insurance include but may not be limited to:

- Case management activities such as telephone calls between SCCF clinicians and clients, attorneys, guardian ad litem, other therapists, etc.
- Letters and reports to clients, court, attorneys.
- Joint sessions between unmarried persons
- Review of legal, educational or past treatment records

An adjusted fee scale may be available for uninsured clients.

Case Management Services:

Because these services require professional time, there is a fee which you will be charged. Since insurance does not cover these costs, 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 rate of \$120.00 (15 minutes would cost \$30.00, 30 minutes, \$60.00, etc.).

Client Signature (legal guardian for client under age 18 yrs)

Date