Samaritan Counseling Center of Greater Birmingham
PO Box 380305, Birmingham AL 35238 205-967-3660 www.samaritanbirmingham.com

*Counselor*_________________ *Location*__________________ *Client #*_________________

Client Information Form for Minors

(One form per individual, couple, or family is all that is necessary)

CLIENT (CHILD) INFORMATION

TODAY'S DATE____________________

Name____
Last First Middle Initial

Mailing address ____
Street City State/Zip code

DOB_____/______/_______ Age_________ ❑ Male ❑ Female

Racial identity ❑ American Indian ❑ Asian ❑ African-American ❑ Caucasian ❑ Hispanic ❑ Middle Eastern

RESPONSIBLE PARTY

Name ____
Last First Mid Initial

Mailing address ____
Street City State/ZIP

Relationship to client ____

	Preferred?	Leave Message?	
Home phone: _______________________	❑	Y ❑ N ❑	Email address: ____________________________
Cell phone: ________________________	❑	Y ❑ N ❑	OK to send text message? Y ❑ N ❑
Work phone: _______________________	❑	Y ❑ N ❑	

Employer ____ Job title/position____________________________________

Highest level of education attained and what school ____

Religious or denominational preference (if applicable): ____

Member of a church? Yes___ No___ If Yes, which church ____

Name of Pastor, Minister, or member of the clergy____

Emergency contact ____
Name Relationship to Client

Contact number ____

SPOUSE/PARTNER

Number of years together: _______________

Name____ DOB_____________ Age_________
Last First

Relationship to client ____

Home phone ___________________________ Cell ___________________________ Work ___________________________

Employer ____ Job title or position ___________________________________

Highest level of education attained ___________________________ Email ____

HOUSEHOLD'S TOTAL INCOME ____ Less than $20,000 ____$20-39,999 ____$40-59,999
____ $60-79,999 ____$80-99,999 ____$100,000 or more

MEMBERS OF HOUSEHOLD

Name	Relation to Client	Sex	Age	Deceased?

CLIENT EDUCATION

School and grade level ________________________________

Teacher ____________________ Academic performance or GPA ____________________

Favorite subject ____________________ Least favorite subject ____________________

Extracurricular activities and hobbies ________________________________

____

PRESENTING PROBLEM *(See also the checklist of concerns on page 4.)*

What brings you to counseling at this time?

____

____

____

Have you (or your family members) ever been involved in counseling? ❑ Yes ❑ No

If yes, name of counselor? ____________________ When? ____________________

Reason(s): ________________________________

Is your child in treatment with another counselor at this time? ❑ Yes ❑ No

If yes, with whom? ____________________ Reason(s) ____________________

MEDICAL HISTORY/HEALTH CONDITIONS

Name of client's primary physician____________________ Phone____________________

Date of last physical____________________ Date of last visit____________________

Please indicate if your child has now or has had any of the following conditions:

____ Arthritis ____ Asthma ____Back problems ____ Cancer
____ Chronic lung problems ____ Diabetes ____Hearing problems ____ Heart problems
____ High blood pressure ____ Kidney problems ____Stroke ____ Thyroid problems
____ Vision problems ____ Weight loss/gain ____Chronic pain ____ Headaches
____ Stomach aches ____ Ulcer/gastrointestinal problems ____ Sexual functioning problems
____ Other ________________________________

Please list all prescribed medications (medication, dosage, frequency, and name of prescribing physician)
____

____

Name of Psychiatrist (if applicable) ______________________________________ Phone____________________________________

Check which of the following your child uses, and please note the amount and frequency of each:

❑ Caffeine______________________________

❑ Coffee ❑ Sodas ❑ Other drinks ❑ Pills/supplements

❑ Alcohol/adult beverages_______________________ ❑ Tobacco___________________________

FUTURE APPOINTMENTS

Should we need to contact you regarding a future appointment, please indicate how we may do this if you are not available when we call. Initial all that apply.

_____ Leave message with appointment day and time on voicemail
_____ If no voicemail, leave appointment time with ____
_____ Leave a message with callback number requesting you contact Samaritan Counseling Centers
_____ Email appointment information
_____ Text appointment information to my cell number

REFERRAL SOURCE

How did you hear about us? ____

If you were referred to us by a specific person, do we have your permission to thank them? ❑ Yes ❑ No

Name & Contact Information of Referral source (if applicable)

____

Consent for Treatment (Minors)

In the state of Alabama, a minor is defined as a person under the age of 14

Name of Minor: _______________________________ **Date of Birth:** _________________

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By signing this this consent form, I, _______________, give permission to _______________________, counselor with Samaritan Counseling Centers of Greater Birmingham (SCC), I also certify that I am the minor(s) legal guardian. I am able to provide proof of my legal guardian status, if SCC requests for such document.

This treatment may include individual, group, and/or family psychotherapy, or psychological testing. I understand that the treatment plan for minors may include referral to other mental health professionals or to appropriate State and/or County agencies for further evaluation or counseling services.

Confidentiality

As client(s) of SCC, the minor is afforded client-counselor confidentiality, as agreed upon with legal guardians/parents. Confidentiality cannot be maintained when:

1. Client state that he/she plan to cause harm or death to self or others. Additionally, if counselor believe that client have the intent and ability to carry out this threat in the near future. Counselor is mandated to report this plan to parents, legal guardians, and, if appropriate, law enforcement. Counselors must make sure that client are protected from harm to self.

2. Client state that he/she is participating in activities that can be harmful to self or others. Counselor will use professional judgement to decide whether parents or guardian should be informed.
3. Client state that he/she is being abused-physically, sexually, or emotionally-, past or present. Counselor is mandated to report the abuse to Department of Human Resources (DHR).
4. Client state that he/she is aware of abuse-physically, sexually, financially, emotionally-, past or present, to vulnerable population, such as elderly, pregnant women, incapacitated individual(s), and person with developmental disability. Counselor is mandated to report the abuse to DHR.
5. Client is involved in a court case, and a request is made for information about your therapy by the judge. Counselor will, to the extent allowed by the law, to protect minor's confidentiality.

We ask that you respect the confidentiality and privacy of others you see in the reception or counseling areas of SCC

Signature of Legal Guardian(s) or Parent(s)	**Signature of Legal Guardian(s) or Parent(s)**
______________________________________	______________________________________
Name in Print:	**Name in Print:**
______________________________________	______________________________________
Date: ___/____/____	**Date: ___/____/____**

____

Street Address (house number, street, city, zip code)

____

Contact information (Primary Phone number, Home, Work, and email)

Client Information and Consent to Treatment

Thank you for choosing Samaritan Counseling Center (SCC) for your counseling needs. We are committed to providing you excellent care. To acquaint you further with the procedures and policies of our centers, we are providing the following information.

SCC's PHILOSOPHY OF INTEGRATION: SCC is a faith-based organization and the counselors have counseling expertise including integrating the client's spiritual beliefs and practices as a part of the therapy process. Our goal is to work within the belief system of the client. Your therapist will not impose their beliefs upon clients; they will include discussion of spirituality, religion, or faith according to the expressed preference of the client.

COUNSELOR CREDENTIALS: Your counselor holds certification from the appropriate national organization or is licensed by the state of Alabama to provide the services you are seeking from the Samaritan Counseling Center.

COUNSELING METHODS: Counseling methods will vary, depending on your primary counselor and individual circumstances. Individual, couple or family sessions may be scheduled. Any questions you have about the procedure or process are always legitimate. You always have the right to decline participation in or the use of certain therapeutic techniques. We do not treat minors (under age 14) without parental consent. Counseling sessions will be fifty (50) minutes, unless otherwise specified by your counselor.

RISK: Counseling often involves change. Processing areas of your life and learning new ways of thinking, feeling, and behaving can cause discomfort for you and those around you. However, if you are committed to your counseling process, you can expect benefits from your counseling time. Please ask for any clarification that may help you feel more comfortable.

EMERGENCY SERVICES and AFTER HOURS CONTACT: Samaritan Counseling Center does not provide emergency services. In the event of an emergency, call or go to the nearest emergency room or contact the Crisis Center at 205.323.7777. Telephone contact between the counselor and client is discouraged and should be limited to five (5) minutes. Telephone sessions lasting over ten (10) minutes will be charged at a rate of normal hourly fees. Use of email or text message contact between the counselor and client requires the completion of an electronic communication consent form.

APPOINTMENTS: Your scheduled office appointment is a time specifically set aside for you. If you are unable to keep an appointment, ***a minimum of 24-hours' notice is required; otherwise you are subject to the full charge for the appointment. If a client fails to appear for a session, the full fee will be charged.***

REFERRALS: The counselor reserves the right to terminate the counseling relationship for any reason deemed to be in the client's best interest. If the counselor or client determines additional or continued counseling is needed, the counselor will provide a referral.

Minor Client(s) Signature ____ Date ______________

Fee Considerations

INSURANCE BILLING: Samaritan Counseling Centers bills only those insurance companies who have been established in advance as accepting a SCC counselor as a provider. Co-pay is expected at the time of counseling services. For non-contracted insurance plans, we require payment at the time of service and you may bill your insurance directly, with the statement you may receive when requested. All fees remain the responsibility of the client.

FEE ADJUSTMENTS: We, the staff of SCC, seek to minister to each of our clients according to our mission and purpose. We understand that, at times, there are circumstances that arise which complicate the ability of our clients to pay the full fee for the service established by our center. As a part of our ministry, we are able to offer limited funds to help offset the cost of your counseling sessions. These subsidies are made possible through the generosity of friends of SCC. We ask that you remember that counseling is an investment. It is an investment in you, in your emotional and spiritual health, and in your relationships. As you consider your financial situation, please consider what this investment is worth to you.

FEE AGREEMENT: The standard fee for therapy is $___________ for a 50-minute session or consult. You are fully responsible for all services rendered. Full payment is expected at the time of service, unless other contractual arrangements apply. If you have financial need, assistance can be provided via adjustment, according to your counselor's discretion. Payment is expected at the time of the visit. The counselor shall receive all payments at the beginning of the session, unless other arrangements have been agreed upon between you and the counselor.

Please review the stated policies concerning our Fee Agreement & Fee Adjustments and initial each indicating that you understand and agree to the policy.

_________ All counseling sessions require a minimum of **24 hour notice** for cancellation. If an appointment is missed or canceled less than 24 hours prior to the session, the client may be charged the full rate.

_________ Payment is expected at the time of service for each session. You may pay by check, cash, Master Card, and/or VISA. Please make all checks payable to **Samaritan Counseling Centers**. You are responsible for any fees charged to Samaritan Counseling for returned checks.

________ The fee for service is $__________. Adjustments are available upon approval.

TO BE COMPLETED BY COUNSELOR

$ ___________________ Counselor Fee

$ ___________________ Adjustment (Show both CAF and other adjustments)

$ ____________________ Client Payment

$ ____________________ 3rd Party Reimbursement for _________ sessions
Fee: _____________ Co-pay: _______________
Managed Care: Auth.#: _____________________

I have reviewed and agree to abide by the financial policy outlined above. I also have read and understand the treatment notifications and am consenting to receive services from a Samaritan Counseling Centers counselor.

____________________________________ ____________________

Client(s) Signature Date

CLIENT NOTIFICATION OF PRIVACY RIGHTS/ HIPAA

CLIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new client protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law", HIPAA provides patient protections related to the electronic transmission of data, the keeping and use of patient records, and storage and access to health care records. HIPAA also applies to mental health client care.

By law, we are required to secure your signature indicating you understand this Client Notification of Privacy Rights document. If you have any questions about Samaritan Counseling Center's Notice of Privacy Rights, please contact the Privacy Officer listed below.

Privacy Officer

Christopher Cheung, PhD
PO Box 380305
Birmingham, Alabama 35238

Telephone: (205) 967-3660
Fax: (205) 573-0211
Email: cwcheung@samaritancc.org

PLEASE SIGN BELOW TO INDICATE YOU HAVE READ AND UNDERSTAND THE CLIENT INFORMATION AND CONSENT TO TREATMENT FORMS, INCLUDING THE CLIENT NOTIFICATION OF PRIVACY RIGHTS SECTION.

____________________________________ ____________________

Client(s) (and/or Guardian) Signature Date

For SCCBham Office use only

Client's Consent/Fee Info Signed	*__Y __N __N/A*	*Demographic Form*	*__Y __N __N/A*
Consent for Minors	*__Y __N __N/A*	*CC on File Necessary*	*__Y __N __N/A*
HIPAA Offered/Signed	*__Y __N __N/A*	*Initial Assessment Summary*	*__Y __N __N/A*
Release of Information	*__Y __N __N/A*	*Treatment Plan*	*__Y __N __N/A*
Prayer or Spiritual Issues Discussed	*__Y __N __N/A*	*Client Satisfaction Form*	*__Y __N __N/A*
Suicidality & Homicidality Assessed	*__Y __N __N/A*	*Discharge Summary*	*__Y __N __N/A*
Insurance Information	*__Y __N __N/A*	*Client Record Audit Date(s)*	*___________*

CHECKLIST OF CONCERNS

Please check any relevant concerns; initial if referring to more than one person.

THOUGHTS/FEELINGS/MOOD

- ❑Anger/frustration/hostility
- ❑Anxiety, nervousness
- ❑Attention, concentration, distractibility
- ❑Confusion
- ❑Depression
- ❑Disliking others
- ❑Emptiness
- ❑Euphoria
- ❑Excessive worry
- ❑Failure
- ❑Fear
- ❑Grieving (death, loss, divorce, etc)
- ❑Guilt
- ❑Hearing things other people don't
- ❑Homicidal thoughts
- ❑Intrusive thoughts
- ❑Judgment problems
- ❑Memory difficulties
- ❑Negative thoughts
- ❑Obsessive thoughts
- ❑Oversensitivity to criticism
- ❑Oversensitivity to rejection
- ❑Panic attacks
- ❑Perfectionism
- ❑Sadness
- ❑Seeing things other people don't
- ❑Self-centeredness
- ❑Self-esteem (low)
- ❑Shyness
- ❑Spiritual, religious, or moral issues
- ❑Stress
- ❑Sudden mood changes
- ❑Suicidal thoughts
- ❑Suspiciousness
- ❑Temper problems
- ❑Thoughts of hurting self or others

BEHAVIOR

- ❑Aggression, violence
- ❑Alcohol use
- ❑Argumentative
- ❑Avoidant
- ❑Bedwetting
- ❑Compulsive behavior/rituals
- ❑Controlling
- ❑Decreased/lack of sexual interest
- ❑Defiance/disobedience
- ❑Dependency, clingy
- ❑Destruction of property
- ❑Drug use: prescription, over-the -counter, street
- ❑Eating problems
- ❑Financial problems, debt
- ❑Gambling
- ❑Hyperactivity
- ❑Internet problems
- ❑Irresponsibility
- ❑Isolation
- ❑Legal problems
- ❑Letting others take advantage of him/her
- ❑Loss of appetite
- ❑Loss of interest in what child used to enjoy
- ❑Lying
- ❑Nightmares/night terrors
- ❑Not able to relax
- ❑Overeating
- ❑Pornography
- ❑Preoccupation with sex
- ❑Procrastination
- ❑Purging
- ❑Self-destruction/sabotaging
- ❑Self-neglect
- ❑Sexual dysfunction
- ❑Sleep difficulty
- ❑Smoking
- ❑Stealing
- ❑Threats
- ❑Weight, gain/loss
- ❑Withdrawal from others

FAMILY & RELATIONSHIPS

- ❑Affair
- ❑Childhood issues
- ❑Divorce
- ❑Friendships/ peers
- ❑Housework/chores
- ❑Interpersonal conflicts
- ❑Parenting
- ❑Problems w/ parents
- ❑Problems w/ siblings
- ❑Problems w/ teacher(s)
- ❑Separation

ABUSE

- ❑Abuse of alcohol
- ❑Abuse of drugs
- ❑Emotional abuse by another
- ❑Emotional abuse of another
- ❑Financial abuse
- ❑Neglect
- ❑Physical abuse by another
- ❑Physical abuse of another
- ❑Sexual abuse by another
- ❑Sexual abuse of another
- ❑Verbal abuse

WORK & SCHOOL

- ❑Absenteeism
- ❑Career concerns, goals, choices
- ❑Difficulty with authority
- ❑Difficulty with coworkers/peers
- ❑Performance
- ❑Procrastination
- ❑School problems
- ❑Tardiness

OTHER CONCERNS

❑______________________________ ❑___________________________ ❑________________________

❑______________________________ ❑___________________________ ❑________________________

Of the items check, which most concerns you? ____

____

❑I have no problems or concerns bringing me here.

(Note: The information requested in this form will be kept strictly confidential.)