Samaritan Counseling Centers of Greater Birmingham

PO Box 380305, Birmingham AL 35238-0305 □ 205-967-3660 □ www.samaritanbirmingham.com

*Counselor*_____ *Location*_____ *Client #* _____

Client(s) Information Form

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

GENERAL INFORMATION **TODAY'S DATE**_____

NAME_____
Last First MidInitial

MAILING ADDRESS_____
Street City State/ZIP

Responsible Party (if different from above)

NAME_____
Last First MidInitial

MAILING ADDRESS_____
Street City State/ZIP

Preferred? Leave Message?

HOME PHONE: _____ ❑ Y ❑ N ❑ Email Address: _____

CELL PHONE: _____ ❑ Y ❑ N ❑ Ok to send Text Message? Y ❑ N ❑

WORK PHONE: _____ ❑ Y ❑ N ❑

DOB_____/_____/_____ AGE_____ ❑ MALE ❑ FEMALE

EMPLOYER_____ JOB TITLE/POSITION_____

HIGHEST EDUCATION LEVEL ATTAINED, WHERE_____

MARITAL STATUS ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Committed Relationship

RACIAL IDENTITY ❑ American Indian ❑ Asian ❑ African-American ❑ Caucasian ❑ Hispanic ❑ Middle Eastern

RELIGIOUS/DENOMINATIONAL Preference (if applicable): _____

MEMBER OF A CHURCH? Yes___ No___ If Yes, WHAT CHURCH_____

Name of Pastor, Minister, or member of the Clergy_____

EMERGENCY CONTACT _____
Name Contact #

RELATIONSHIP TO YOU _____

SPOUSE/PARTNER # of Years Together: _____

NAME_____ DOB_____ AGE_____
Last First

HOME PHONE_____ CELL_____ WORK_____

EMPLOYER_____ JOB TITLE/POSITION_____

HIGHEST EDUCATION LEVEL ATTAINED_____ EMAIL _____

CHILDREN

Name	Sex	Age	Deceased?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

HOUSEHOLD'S TOTAL INCOME

____ Less than $20,000 ____$20-39,999 ____$40-59,999
____$60-79,999 ____$80-99,999 ____$100,000 or more

PRESENTING PROBLEM

(please see checklist of concerns)

Reason for seeking counseling services:

_____

_____

_____

_____

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

If yes, with whom? _____ When?_____

Reason(s): _____

Are you in treatment with another counselor at this time? ❑ Yes ❑ No If yes, with whom? _____

Reason_____

MEDICAL HISTORY/HEALTH CONDITIONS

Name of Primary Physician_____ Phone_____

Date of Last Physical_____ Date of Last Visit_____

Please indicate if you have now or have 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
____ Stomachaches	____ Ulcer/Gastrointestinal Problems		____ Sexual Functioning Problems

____ Other _____

Please list all prescribed medications (Medication, Dosage, Frequency, & Name of Prescribing Physician)

_____

_____

_____

Name of Psychiatrist (if applicable) _____ Phone_____

Check which of the following you use, 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 your future appointments, please indicate how we may do this if you are not available when we call. Initial all that apply.

_____ Leave appointment time on answering machine/voicemail
_____ If no answering machine, leave appointment time with _____
_____ Leave a message with callback number requesting you contact Samaritan Counseling Center
_____ Email appointment information

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)

_____

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
Main Office: 300 Cahaba Park Circle, Suite 202
Birmingham, Alabama 35242
Telephone No. (205) 967-3660
Fax No. (205) 573-0211
Email address: info@samaritanbirmingham.com

Note: Check with your therapist for the location of your appointment.

PLEASE SIGN BELOW TO INDICATE YOU HAVE READ AND UNDERSTAND THE CLIENT INFORMATION AND CONSENT TO TREATMENT FORM, 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
- ❑Fatigue
- ❑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
- ❑Compulsive behavior/rituals
- ❑Controlling
- ❑Decreased/lack of sexual interest
- ❑Dependency
- ❑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 you
- ❑Lying
- ❑Not able to relax
- ❑Pornography
- ❑Preoccupation with sex
- ❑Procrastination
- ❑Purging
- ❑Self destruction/sabotaging
- ❑Self-neglect
- ❑Sexual dysfunction
- ❑Smoking
- ❑Stealing
- ❑Threats
- ❑Weight, gain/loss
- ❑Withdrawal from others
- ❑Loss of interest in what I used to like
- ❑Sleep difficulty
- ❑Loss of appetite
- ❑Overeating

FAMILY & RELATIONSHIPS

- ❑Affair
- ❑Childhood issues (your childhood)
- ❑Divorce
- ❑Friendships
- ❑Housework/chores
- ❑Interpersonal conflicts
- ❑Parenting
- ❑Problems w/ child(ren)
- ❑Problems w/ parents
- ❑Problems w/ spouse/partner
- ❑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 coworkers
- ❑Difficulty with supervisor
- ❑Performance
- ❑Tardiness
- ❑Procrastination
- ❑School problems

OTHER CONCERNS

❑_____ ❑_____ ❑_____

_____ _____ _____

❑I have no problems or concerns bringing me here.

(The information requested in this form will be kept confidential)

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.

CONFIDENTIALITY: At SCC, we strive to maintain privacy and uphold the ethics of confidentiality. This includes all verbal, written and recorded data concerning your treatment, which may not be released without your written consent. Limitations to these rights are: **1) We have a legal duty to warn and protect persons threatening harm to self or others, 2) We have a legal duty to report to proper authorities any knowledge of abuse to children and vulnerable adults, 3) We have to comply with Alabama State Laws in regard to court ordered subpoenas/court testimony, 4) If you request reimbursement from your insurance company, they may request reports from your counselor in order to authorize reimbursement.** If you choose to keep a third-party informed of your progress in counseling, it is necessary to complete an "Authorization to Release Information" form that will be kept on file.

Your client record is the property of SCC and shall be treated as confidential. To insure quality record maintenance and client confidentiality, SCC conducts routine client record audits. To comply with state and federal laws regarding client confidentiality, your records will not be released without a properly executed written consent. SCC maintains your record in a locked secure manner for 7 years past the date of your last appointment at which point the records are shredded and disposed of in a confidential manner.

In an effort in enhance the client's counseling and therapeutic experience, and to maintain high standards of care and accountability, collaborative consultations between staff members or with clinical supervisors take place within a professional consultation context. Such consultation is provided with protection of client's identity.

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

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.

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-hours 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

$ _____ 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