Instructions for Completing Intake Paperwork

Welcome to Samaritan Center of North Puget Sound. Please take a few minutes to complete the following paperwork in this packet before you meet with your therapist.

Client Intake and Insurance Information (Page 1)

Complete one of these forms for yourself. Each additional person is to complete his/her own.

Family History (Page 2))

This form is for your therapists review and helps them with some information about you. If you are unsure about how to complete the form, ask your therapist to assist you during your appointment.

Questions to Ask Your Insurance Provider

Listed are questions for you to ask your insurance provider, as needed—typically by calling the 800 number on your insurance card, or by looking at their website.

Fee Agreement (two copies – one for you and one for Samaritan)

You may have clarified your fee with your therapist via phone prior to this session, or it may be set at the first session. Please read and sign at the bottom of both copies. Each additional person is to do the same.

Notice of Privacy Practices (one copy for you)

You may read this now or later after your first session. Please keep it for your records.

Disclosure Statement (two copies – one for you and one for Samaritan) --*Not yet available online*

Please read this, print your name in the space for 'client name,' then sign and date once above and below where indicated on the last page. If you are coming with others, have them read and double-sign the last page as well. Repeat this for the second copy. Your therapist will sign and return your copy.

EAP Information (Employee Assistance Program)

If you are using your workplace Employee Assistance Program, complete the top half of this form and double-sign and date it. Otherwise, write "NA" at the top.

When you are finished completing this packet, please keep it in your possession and hand it to your therapist when s/he meets you.

Questions to Ask Your Insurance Provider Concerning Mental Health Benefits

Do I have behavioral or mental health coverage?
Do I need to have a referral from my Primary Care Physician?
Do I need to have pre-authorization from the insurance company?
Am I only authorized to see a particular kind of therapist? (Psychiatrist, Psychologist, Licensed Mental Health Counselor, Licensed Marriage and Family Therapist, Licensed Clinical Social Worker, etc.)?
Am I limited to a certain number of sessions of therapy (per fiscal year, calendar year)?
What is the effective date of insurance coverage?
Am I limited to a dollar amount per year ($500, $250) that will be covered?
What is my deductible and co-pay after insurance adjustment is applied?
If I am authorized to see one therapist and that does not work out, do I need to get authorization for a different therapist?

For Office Use Only

Date________________________

Counselor___________________

Fee_________________________

SAMARITAN COUNSELING CENTER

FOR CONFIDENTIAL USE ONLY

(Couples please fill out for both)

Patient / Client________________________________ Patient / Client ____________________________________
Spouse or Parent if child

Address_______________________________________ Address____

City & Zip_____________________________________ City & Zip_______________________________________

Phone: (Hm)_____________ (Wk)________________ Phone: (Hm)_____________ (Wk)___________________

Cell __________________ Email_________________ Cell __________________ Email____________________

Soc. Sec. Number _____________________________ Soc. Sec. Number_________________________________

Date of Birth __________________Age_____ Sex____ Date of Birth____________________ Age____ Sex____

Occupation____________________________________ Occupation______________________________________

Employer's Name_______________________________ Employer's Name_________________________________

Church Affiliation_______________________________ Church Affiliation _______________________________

Referred By:___________________________________ If by Doctor:_____________________________Y / N
Name OK to Call?

Type of Counseling Requested: ___________(**I** = Individual, **C** = Couple, **F** = Family, **G** = Group)

For subsidized fees request: Combined Gross Income for Household $ ___________ Number of Persons in Household_____

INSURANCE COVERAGE: Yes_____ No_____

If YES, Complete Insurance Information and sign Form.

INSURANCE COMPANY______________________________

INSURANCE PHONE # ______________________________

ADDRESS____
A copy of your card is helpful.

Subscriber Name______________________

Subscriber ID#_______________________
Subscriber identification number from ID Card – Include alpha prefix if applicable.

Subscriber DOB_______________________

Employer ____________________________
Subscriber's Employer please.

Relationship: SELF SPOUSE PARENT
Please circle relationship to subscriber

Group # ____________

Do you have other insurance? Y / N

Circle Status

	Single	Partnered	Married	Remarried
Date	_____	________	_______	________
	Separated	**Widowed**	**Divorced**	
Date	_______	________	_______	

RELATIONSHIP HISTORY

	Single	Partnered	Married	Remarried
Date	_____	________	_______	________
	Separated	**Widowed**	**Divorced**	
Date	_______	________	_______	

Children & Family History on Page 2

I hereby assign and transfer to Samaritan Counseling Center all insurance benefits or proceeds payable as a result of all procedures or services to be performed or rendered by SCC. SCC is hereby authorized to apply for and receive the same. I have read and understand the Privacy Practices of SCC and my rights regarding my PHI. I agree to cooperate in the completion of appropriate claim forms or statements as requested by SCC or the insurance carrier. The undersigned do each agree to be fully responsible for payment of the reasonable charges incurred as a result of the procedures or services performed or to be performed by SCC including collection and/or attorney fees.
All charges are due upon billing. All Copays and Coinsurance due at the time of service.

____
Insured Signature Date

____
Patient Signature Date

____
Parent/Guardian Signature if client is a Minor: (Name & Relationship – Please Print) Date

DIAGNOSIS CODE ______________

****Samaritan Counseling Center of North Puget Sound: Referred to as SCC**

FAMILY HISTORY – Intake Page 2

Children:

Name:	Age	Birth-date	Sex	Whose Child?	Living with you?	Dependent?
					Y / N	Y / N
					Y / N	Y / N
					Y / N	Y / N

If more space is needed. Please list on back.

If for couples, please complete for both.

Parents of Client:
Father's Name: ______________________________

Living_____ Deceased_____ Age_____

Divorced? ____ Widowed?____ Remarried? ___

Mother's Name: ______________________________

Living_____ Deceased_____ Age_____

Divorced? ____ Widowed?____ Remarried? ___

Number of Brothers:______ & Sisters: ______
I was born 1st _____ 2nd _____ 3rd _____other_____

Brother / Sister name: Age:

____

____

____

____

Medical Doctor:______________________________
Phone Number:______________________________
Date of Last Checkup:________________________
Current Medications: _________________________
Prescribed by:______________________________
(If different than doctor listed above.)

Stresses / Disturbances:	Yes	No
Sleep	___	___
Food	___	___
Alcohol	___	___
Other Drugs	___	___
Anxious/worried	___	___
Feeling Blue	___	___

Normal hours of sleep: _____
Previous Counseling:__ Pastor __ Psychologist

___ Psychiatrist ___ Other

When: _________________

Name of counselor you saw: ___________________

Parents of Client:
Father's Name: ______________________________

Living_____ Deceased_____ Age_____

Divorced? ____ Widowed?____ Remarried? ___

Mother's Name: ______________________________

Living_____ Deceased_____ Age_____

Divorced? ____ Widowed?____ Remarried? ___

Number of Brothers:______ & Sisters: ______
I was born 1st _____ 2nd _____ 3rd _____other_____

Brother / Sister name: Age:

____

____

____

____

Medical Doctor:______________________________
Phone Number:______________________________
Date of Last Checkup:________________________
Current Medications: _________________________
Prescribed by:______________________________
(If different than doctor listed above.)

Stresses / Disturbances:	Yes	No
Sleep	___	___
Food	___	___
Alcohol	___	___
Other Drugs	___	___
Anxious/worried	___	___
Feeling Blue	___	___

Normal hours of sleep: _____
Previous Counseling:__ Pastor __ Psychologist

___ Psychiatrist ___ Other

When: _________________

Name of counselor you saw: _________________

Reason for coming today: ____

____

____

Fee Agreement

Appointments

Counseling sessions are normally 45-50 minutes in length, including rescheduling and payment. Consistency in keeping appointments is important to the counseling process. When canceling or rescheduling an appointment, 24 hours notice is expected at minimum. If clients are unable to provide timely notice or miss an appointment, they may be charged the full amount for the session.

Samaritan Fee Policies

The standard fee for a counseling session at Samaritan is $150 for psychologists and $120 for all other psychotherapists. A client who does not have the means to pay the standard fee may qualify for an adjusted fee as provided by Samaritan's fee adjustment schedule. This is made possible by subsidies from the greater community or the agency.

A client's fee-per-session is determined at the first session, or beforehand via telephone. Because additional administrative and clinical staff time is required to set up a new client account and treatment plan, a one-time first session- fee (which is 1.5 times the regular fee-per-session) is charged to cover the first session. Payment in full (or payment of one's deductible and/or co-pay, in the case of insurance) should be given to the counselor at the beginning of each session. The fee-per-session may be adjusted up or down if financial circumstances change. If a client's account becomes more than two sessions past due, the counselor will not be able to schedule additional appointments until payments are current. During the course of treatment if a client requests additional services such as (but not limited to) phone consultations, reports, correspondence or the copying of records, prorated charges will apply.

Client Agreement to Pay for Service

I agree to pay all charges for services that I incur. If I use insurance to cover some or all of my counseling at Samaritan, I agree to pay any amounts that my insurance carrier does not pay. These may include, but are not limited to, services and charges determined by my insurance carrier not to be medically necessary, and/or services and charges not covered by my insurance plan. If I incur a charge for a missed or late-canceled appointment, I understand that I will be responsible for payment of the agreed-upon fee per session. The following are my agreed upon fees:

Samaritan Counseling Center

COUNSELING FEE AGREEMENT

Our counseling cost for a psychologist is $150.00 for each 45-55 minute session. It is part of our mission to serve people who are unable to pay the full fee. Your counselor will discuss your needs according to our cost, your income, and family size. You will be asked to pay each session as it occurs.

If you cannot pay for a session, you are asked to pay for it at the beginning of the next session.

You may also use one of the following payment plans:

A. [ ] I (we) agree to pay $__________________each session.

B. [ ] I (we) agree to pay $__________________in advance for each set of four sessions.

C. [ ] I (we) agree to pay $__________________per month until the unpaid balance is paid in full.

CLIENT SIGNATURE____

CLIENT SIGNATURE____

DATE:__________COUNSELOR'S SIGNATURE____________________

Samaritan Counseling Center

P O Box 292, Snohomish, WA 98291-0292
samaritannps.com

NOTICE OF PRIVACY PRACTICES

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

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. The previous Notice of Privacy Practices is being amended by this Notice and there are no significant changes to our privacy practices. The effective date of these privacy practices is April 14, 2003. They will remain in effect until amended or replaced.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer. Information on contacting us can be bound at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION
We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established “minimum necessary or need to know” standards that limit various staff members’ access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other healthcare professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree in writing, that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use of disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to make reasonable inferences of your best interest.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and /or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that or others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders. Including but not limited to voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR CLIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $ ______ for pages 1-5 and $_____ thereafter and the staff time charged will be up to $ _______ per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of these routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment or healthcare operations. You can request a list of non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. (Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your rights to the privacy of your information and will not retaliate in anyway if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US

Privacy Officer:
Barbara J. Brown, LICSW
Samaritan Counseling Center
1306 Lakeview Drive
PO Box 292
Snohomish, WA 98291-0292
360-568-8737

EAP Information

(Employee Assistance Program)
Client:
First Name ________________________ Last Name __________________________

Social Security # __________________ Birth Date _______________________

Gender: Male_____ Female______

Marital Status: Single_____ Married_____ Other_____

I authorize the release of any medical or other information necessary to process this claim or any further claims.

____ Date_____________________
Client or Authorized Person's Signature

I authorize payment of EAP benefits to Samaritan Center of Puget Sound.

____ Date ____________________
Insured or Authorized Person's Signature

EAP Information: To Be Completed by Therapist
Therapist Bills_________ Office Bills___________
Number of sessions authorized:_____ Authorization Dates: From________ to________
Authorization Number:_________________________________
Client Relationship to Insured: Self______ Spouse______ Child_____ Other________
EAP Company:____
EAP Address: ____
Phone Number: ____
Employer Name: ____
Therapist: ____
Diagnosis: ____

The **Disclosure Statement** form of your therapist is not available on our website. Two hardcopies (one for you and one for Samaritan) will be available for you to sign and date at your first session.