Samaritan Counseling Center - Cash or Insurance Client Information

Date _____

(Last Name) (First Name) (Middle or Initial)

Date of Birth_____/_____/_____ Age_____ **Male** ◯ **Female** ◯

Address_____City_____Zip_____

Cell/Home Phone _____ OK to call? ☐ Alternate phone_____ OK to call? ☐

Email_____ Ok to contact? ◯ Ok to receive communication/newsletter? ◯

Who is the responsible billing party:_____ Insurance Company:_____

Name of Parent or legal guardian (if under 18):_____

How did you hear about us?_____

Demographic Statistical Information

Ethnic Background: African American ☐ Asian/Pacific Islander ☐ American Indian ☐ Hispanic/Latino ☐ White/Caucasian ☐ Other/Multi-Racial ☐ Unknown ☐		
Do you attend church? Y ◯ N ◯ Name of Church:		
Marital Status: Single ◯ Married ◯ Separated ◯ Divorced ◯ Widowed ◯ Other (Specify):		
Total Yearly Household Income:	# of people in your household (including yourself):	# of children living with you under age 18:

SAMARITAN COUNSELING CENTER

Consent to Treatment/Client's Rights

THE AGENCY: The Samaritan Counseling Center was founded in 1973 to meet an expressed need for community-based counseling. Many churches in our community support the Center as an outreach of their ministry to hurting persons. Our nonprofit status and other community funding enable us to offer to you high quality counseling at affordable rates.

THE THERAPISTS: Our therapists are highly qualified as generalists and also have advanced training in an additional area of specialty. They each are involved in ongoing training in order to be informed of the latest developments and theories in their particular fields.

CONFIDENTIALITY: All counseling done in our offices is held in strict confidence. We will consult with other professionals (i.e., your physician, pastor, teacher) only after you have given us written permission to do so. In the event that your therapy is provided by an intern, your case will be supervised by the appropriate professional supervisor. If we need to phone you at home or at work, we will identify ourselves by using a first name only.

LIMITATIONS TO CONFIDENTIALITY: State law requires that confidentiality be suspended and information disclosed to avoid danger to others when:

1) The therapist thinks that a client is genuinely threatening bodily harm to another. The therapist must warn the intended victim and notify the police.
2) When a therapist has reasonable knowledge that a person over age 65 or a dependent adult has been physically abused.
3) The therapist suspects or has direct knowledge that a child is or has been sexually abused, physically abused or neglected. The therapist must report to a child protective agency.
4) The therapist thinks that a client is making a genuine threat to do bodily harm to himself/herself, and/or the therapists thinks that a client is gravely disabled and thus incapable of caring for himself/herself. The therapists must then take active steps to insure that the client's well-being is taken care of by outside agencies.
5) To input demographic information into the County's secure database for purposes of invoicing.

EMERGENCIES: The Samaritan Counseling Center is not a crisis counseling center nor do we maintain a 24-hour crisis hotline. The phone is answered in the business office between the hours of 8:30 a.m. and 5:30 p.m. Monday through Friday. An answering machine is in place during non-business hours for clients to leave messages pertaining to scheduling or canceling appointments. If, in your particular situation, you anticipate needing to reach your therapist on an emergency basis, please make this need known to our therapist at this initial appointment so appropriate arrangements can be made prior to a crisis arising. Otherwise, we recommend telephoning 911.

Your signature below indicates that you have read and understand these provisions, and that you are giving consent for treatment here at the Samaritan Counseling Center.

Your signature below also indicates that you have reviewed a copy of the center's Notice of Privacy Practices and Grievance Procedures.

_____

Signature of Client Date (Relationship if other than counselee)

SAMARITAN COUNSELING CENTER

A Brief Family History:

Name _____ Date _____

Date of Marriage, if any _____ Spouse's name _____

Date(s) of previous marriages (s) _____

Your father's/stepfather's name _____ Age _____

Your mother's/stepmother's name _____ Age _____

List your children: (If child is client list siblings)

First Name	Gender	Age	Living?	Marital Status

Overall how would you rate your health?

Excellent _____ Good _____ Fair _____ Poor _____

List any serious illness you currently have:

_____

Significant Hospitalizations:

_____

Current physician, and telephone :

_____

Please list any medications you're currently taking, their dosage, and purpose:

_____

_____

Are you currently receiving mental health services somewhere else?

_____

Are you currently participating in an alcohol or substance program?

_____

Are these counseling services court ordered or a condition of any probation?

_____

SAMARITAN COUNSELING CENTER
1126 W. Foothill Blvd, Suite 110
Upland, CA 91786
Office: (909) 985-0513 **Fax:** (909) 985-7193

DECLARATION OF AGREEMENT REGARDING MISSED OR CANCELLED APPOINTMENTS

In order to provide quality professional counseling Samaritan Counseling Center must charge a fee for its services. When an appointment is missed or cancelled with less than 24 hours prior notification we must, regrettably, charge for the session.

I understand and agree to the following:

1. It is my responsibility to notify my Therapist or the Office Manager at Samaritan Counseling Center 24 hours prior to the scheduled appointment if I am unable to keep the appointment.
2. I agree that I will be billed for the cost of the full session at the rate of $_____ in the event that I miss an appointment or fail to cancel 24 hours prior to the scheduled appointment.

_____
Client Name (print)

_____
Client Signature

_____
Therapist Name

_____
Date

SAMARITAN COUNSELING CENTER
Serving Individuals, Couples, and Families since 1973
Doug McKown, Psy.D., Executive Director

Credit/Debit Card Authorization Form

Credit/Debit Card Details

Card Type: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Cardholder Name:_____

Card Number:_____

Expiration Date:_____

CVV:_____

Billing Information

Billing Address:_____

City:_____

State:_____ Zip:_____

Phone:_____

e-mail:_____

Consent

I, the undersigned cardholder, authorize the merchant known as Samaritan Counseling Center to charge my credit/debit card for counseling sessions and other services (no show/late cancel fee, additional report, court, etc.) as discussed with the therapist. I agree that my information may be saved by the merchant for future payments and understand that this can be revoked at any time with request.

Cardholder's Signature: _____ Date: _____

Please note: An additional Payment Processing Fee is included on all credit/debit card transactions.

SAMARTIAN COUNSELING CENTER

SELF ASSESSMENT FORM

Name _____ Staff _____

Age _____ Gender: M F

Today's Date _____

	Never	Rarely	Sometimes	Frequently	Almost Always
1 I have trouble falling asleep or staying asleep	0	1	2	3	4
2 I feel stressed at work, school or other daily activities	0	1	2	3	4
3 I blame myself for things	0	1	2	3	4
4 I am satisfied with my life	0	1	2	3	4
5 I feel resentful	0	1	2	3	4
6 I have thoughts of ending my life	0	1	2	3	4
7 I feel overwhelmed	0	1	2	3	4
8 I find my work/school or other daily activities satisfying	0	1	2	3	4
9 I have difficulty communicating clearly	0	1	2	3	4
10 I feel worthless	0	1	2	3	4
11 I am concerned about family troubles	0	1	2	3	4
12 I feel sad	0	1	2	3	4
13 I have frequent arguments	0	1	2	3	4
14 I have difficulty concentrating	0	1	2	3	4
15 I feel hopeless about my life	0	1	2	3	4
16 I worry a lot	0	1	2	3	4
17 People criticize my drinking (or drug use)	0	1	2	3	4
18 I have trouble getting along with friends and close acquaintances	0	1	2	3	4
19 I have trouble at work/school or other daily activities because of drinking or drug use	0	1	2	3	4
20 I feel that something bad is going to happen	0	1	2	3	4
21 I feel nervous	0	1	2	3	4
22 I am troubled about my past	0	1	2	3	4
23 I feel hurt when I think about how my life has gone	0	1	2	3	4
24 I feel forgiven	0	1	2	3	4
25 I am satisfied with my relationships with loved ones	0	1	2	3	4

If you wish, please describe any additional concerns which you bring to counseling