Intake Checklist

Please be sure to have the following paperwork filled out and included in your return packet to Samaritan Counseling Center to be added to our telehealth patient intake list. You will receive a call from our intake coordinator confirming the receipt of the packet.

- ☐ Intake form for new and returning clients
- ☐ AGREEMENT FOR THERAPY release form
- ☐ Informed Consent for Teletherapy Services
- ☐ A copy of your driver's license or state ID card
- ☐ A copy of your CURRENT insurance card

- ☐ AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (can be filled out to release information or consult with Primary Care Physician **IF** requested by your therapist

- ☐ CONSENT TO TREAT MINOR CHILDREN (if the teletherapy is for a minor)

Samaritan Counseling Center
Illuminating Minds. Impacting Lives.

AGREEMENT FOR THERAPY

The guidelines outlined here will help you and your therapist work together most effectively.

Appointments: Therapy sessions are generally scheduled for 53-60 minutes. If you are unable to keep a scheduled appointment, call the office. Samaritan Counseling Center is a fee-for service organization. As such, **the Center may charge a fee of $60 for 'no shows' or cancellations with less than 24 hours' notice.** Unforeseen emergency situations and illness will be taken into account. A charge of $25.00 will be made for any returned check.

Fees and Payments: A standard fee is charged for each session and payment is expected each time you are seen. If you have insurance, you must pay your co-pay and any insurance deductible. We encourage you to speak with your insurance company directly so that you understand how they will pay for these services. **YOU MUST INFORM US IMMEDIATLEY OF ANY INSURANCE CHANGES AND YOU ARE RESPONSIBLE FOR PAYING ALL CHARGES INCLUDING DEDUCTIBLES, CO-PAYS AND RELATED ITEMS NOT COVERED BY INSURANCE OR LATER RETRACTED. ACCOUNTS NOT PAID WITHIN 90 DAYS MAY GO TO COLLECTIONS AND A $25 FEE WILL BE ASSESSED.** Regular payment on your part allows us to afford to provide consistent quality service. This fee can be adjusted where necessary and as our funding allows. If this is a concern for you, discuss it with your therapist.

Confidentiality: Your relationship to your therapist and to the Center is a personal and private matter. On occasion, your therapy may be enhanced by information from other professionals with whom you have had contact. No contact will be made with any outside person and/or agency without your written permission. However, contact with other persons or agencies will be made if the therapist considers you to be at serious personal risk. This could include concerns about suicide, homicide, child abuse, or child maltreatment.

Our Samaritan Approach: Samaritan counselors provide holistic, mental health counseling services regardless of race, gender, orientation, or religion and consider counseling to be a healing and empowering process involving the whole person—body, mind, spirit and community. Our therapists are well practiced working within the belief system of clients to include their spiritual and religious beliefs and practices as part of the therapeutic process. Therapists do not impose their personal beliefs upon clients and include discussion of spiritual issues according to the expressed preference of the client.

Electronic Communication: We strongly recommend clients utilize the Patient Portal for confidential communication with counselors. However, if you prefer to communicate by text or email, knowing that these methods of communication are NOT secure for maintaining client confidentiality, please initial your authorization here: _____

I have read, understood, and agree to the guidelines explained here. Furthermore, I have been offered a copy of the Samaritan Counseling Center of the Southern Tier, Inc.'s ***Notice of Privacy Practices*** (copies are available in the waiting room).

Date _____ Print Your Name _____

Print Client's Name (if minor) _____

Your Signature _____

If Couple or an Additional client being seen, please complete below:

Date _____ Print Name _____

Signature _____

Rev 05/1/18

Samaritan Counseling Center

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Informed Consent for Teletherapy Services

The guidelines outlined here will help you and your therapist work together most effectively.

1) I understand that teletherapy is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider. I understand that I may expect the benefits such as convenient access to care and more efficient use of teletherapy but that no results can be guaranteed or assured.

2) I understand that the laws that protect privacy and confidentiality of medical information also apply to teletherapy. As always, my insurance carrier will have access to my medical records for quality review/audit. I understand that I have the right to access my medical information and copies of my medical records in accordance with the laws pertaining to New York State.

3) Samaritan Counseling Center will bill insurance for teletherapy in accordance with my insurance plans. In the event that my insurance does not cover teletherapy and I wish to pay out of pocket for these services there will be a discounted fee of $60/session. If there is a technical issue that prevents us from completing a session SCC will not bill me or my insurance for that session if it is under 30 minutes. I understand I will be responsible for any copayments or coinsurances that apply to my teletherapy session. I understand that my healthcare information may be shared with other individuals for scheduling or billing purposes.

4) I understand that I have the right to withhold or withdraw my consent to the use of teletherapy in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting my provider. As long as this consent in in force (has not been revoked) my provider may provide health care services to me via teletherapy without the need for me to sign another consent form.

5) I further understand that there are risks unique and specific to teletherapy, including but not limited to, the possibility that my therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons. I understand that certain situations, including emergencies and crises, are inappropriate for teletherapy services. If I am in crisis or experiencing a healthcare emergency, I should immediately call 911 or seek help from a hospital or crisis-oriented health care facility.

6) I have read this document carefully and understand the risks and benefits related to the use of teletherapy. I hereby give my informed consent to participate in the use of teletherapy services for treatment under the terms described herein

_____

Print Name

_____ _____

Client's Signature Date

_____ _____

Parent/Guardian/Legal Representative Date

Samaritan Counseling Center
Illuminating Minds. Impacting Lives.
Phone: 607-754-2660 FAX 607-754-0769 e-mail: Office@SamaritanCounseling.org

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

This authorization is to be completed by the client or his/her personal representative to use/disclose Protected Health Information (PHI) in accordance with State & Federal laws & regulations that govern the release of confidential records, as well as Title 42 of the Code of Federal Regulations that governs the release of drug and alcohol records. A separate authorization is required to use or disclose confidential HIV information.

Client Name:_____ Client D.O.B. _____

I DECLINE THIS AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION _____(INITIAL)

I authorize an exchange of Protected Health Information (PHI) between:

The Samaritan Counseling Center
3001 E. Main Street
Endwell, NY 13760
Samaritan Center contact name:
_____

And: **(Name, title, address of person/organization/facility/program)**
Name/Title: _____
Agency/Address _____
Street Address _____
City/State/Zip _____
Phone/Fax _____

	Request	Release		Request	Release
Entire Record	☐	☐	Psychological Testing	☐	☐
Discharge Summary	☐	☐	Psychosocial assessment	☐	☐
Medication Records	☐	☐	School Records	☐	☐
Physical Health Info	☐	☐	Treatment Plans	☐	☐
Progress Notes	☐	☐	Verbal communication	☐	☐
Psychiatric assessment	☐	☐	Other (specify)_____	☐	☐

I hereby permit the use/disclosure of the indicated PHI to the Person/Organization/Facility/Program identified above. I understand that:

- only this information may be used /disclosed as a result of this authorization;
- this information is confidential and cannot legally be disclosed or re-disclosed without my permission;
- I have the right to take back this authorization at any time. This revocation must be in writing on a form provided by Samaritan Counseling Center. I am aware that my revocation does not effect information already disclosed.

☐ I hereby authorize the **periodic disclosure** of the information described above to the Person/Organization/ Facility/Program identified above as often as necessary to fulfill the purpose identified above, and this authorization will expire on the following _____[Date].

☐ I hereby permit **one time disclosure** of the information described above to the Person/Organization/ Facility/Program identified above, and this authorization will expire on the following _____[Date].

_____ _____ _____
Signature of Client or Personal Representative | Printed Name of Client /Representative | Date

_____ _____
Printed Name of Witness | Signature of Witness /Date

Samaritan Counseling Center

CONSENT TO TREAT MINOR CHILDREN

Please print all information

I, _____, parent or legal guardian
parent or legal guardian's name

of _____,
child's name

born _____,
child's birthdate

do hereby consent to any therapy and or treatment(s) determined to be necessary

by a staff therapist for my child while said child is under the care of

_____
therapist's name

and I am not reasonably available by telephone to give consent.

This authorization is effective beginning _____.
today's date

_____
Signature of Parent or Legal Guardian

This additional information will assist in treatment if it can be furnished with the consent but is not required.

_____

This consent form should be taken with the child to the hospital or physician's office when the child is taken for treatment.

SAMARITAN COUNSELING CENTER
3001 EAST MAIN ST, ENDWELL, NY 13760
(607)754-2660

SAMARITAN COUNSELING CENTER

Intake Form for New and Returning Clients

Date: _____

We see children under 18, adults, and couples. If the client is under age 18, please tell us who their Parent or Guardian is. We also need the names of both people seeking Couples work

Name of Client	**Client's Parent** /Guardian or **Partner** (couple)
Date of Birth: _____	Date of Birth:_____
___ Female ___ Male ___ Non-binary	___ Female ___ Male ___ Non-binary
Address _____	Address _____
_____	_____
Email _____	Email _____
Phone: _____	Phone: _____
Ok to leave a message here? Yes / no	Ok to leave a message here? Yes / no
Emergency Contact: _____	Emergency Contact: _____
Would you like appointment reminders?	Would you like appointment reminders?
Yes / No: ____ by phone call, _____ text	Yes / No: ____ by phone call, _____ text
Have you seen one of our therapists before, or been seen at Samaritan in the past?	Have you ever seen one of our therapists before, or been seen at Samaritan in the past?
Yes / no Therapist Name _____	Yes / no Therapist Name _____

Marital status of Client: Single, Married, Divorced, Separated, Partnered, Widowed

Name of Insurance Plan / Company _____

ID # (with any prefixes): _____

Policy Holder Name: _____ Date of Birth_____ Male_____ Female _____

Insurance Holder's Relationship to client: ____ Self, ____ Spouse, ____ Parent, ____ Guardian, ____ Other ____

Please list any Secondary Insurance Plan: _____

Briefly describe what you hope to accomplish through counseling? _____

_____

_____

SAMARITAN COUNSELING CENTER

The following questions help us better know if we may be able to meet your specific needs, and what therapist may be the best fit for you. We may be able to get you an appointment within the month. Other times, you might need to wait awhile for an appointment to open up.

- Are you seeking help to get Disability, Financial Assistance, or for a Legal Case? _____ Yes _____ No
- Are you seeking help because the Court is involved or Child Protective Services? _____ Yes _____ No

- Do you come from a history of physical, sexual, or emotional abuse or neglect? _____ Yes _____ No
- Have you been to CPEP, Inpatient Psychiatric Care, or Rehab in the last 6 months? _____ Yes _____ No

Please circle all the concerns below that relate to you:

Sadness Grief / loss Lack of Motivation Suicidal thoughts / feelings /attempt
Guilt Depression Troubled dreams Child behavior problems
Anxiety Self-doubt Loss of self-respect Thoughts of hurting others
Guilt Shutting-down Domestic Violence Religious doubts / concerns
Fear Nervousness Self-harming Relationship with Parents
Anger Gender Issues Problems with food Relationship with Children
Illness Sexual Issues Drug / alcohol issues Relationship with Spouse / Partner

Medical Concerns or Conditions_____

Prescribed mental health medication: _____

Name of Prescriber _____ Circle: Primary Doctor, FNP, Psychiatrist, Other_____

Please note that there is much demand for appointments after 3 pm, if you absolutely need an ongoing appointment at this time, you may have a longer wait for a therapist.

Please indicate all the times you could be available to meet:

Day: 8 am thru 2 pm __ Monday, __ Tuesday, __ Wednesday, __ Thursday, __ Friday
Evening: 3 pm thru 8 pm __ Monday, __ Tuesday, __ Wednesday, __ Thursday, __ Friday

Would you meet by ___ Phone Tele-health, ___ Video Tele-health, ___ in Office

Are there any Special Needs for the Appointment (such as Handicap Access) ___Yes ___ No

- If you are hoping for a very specific treatment such as EMDR, Mindfulness, Cognitive, Solution-Focused, Family Therapy, etc. _____ (please tell us).

Would you circle your Religious Background: Christian, Baptist, Catholic, Episcopal, Lutheran, Methodist, Presbyterian, Pagan, Jewish, Muslim, Buddhist, None, Other_____

How were you referred to our office? (Circle one): Family, Friend, Clergy _____ (name) Physician _____ (name), School_____ (name), Legal Services, Social Services, Insurance or EAP, an Ad, the Internet, TV or Radio, a sign, or card on a Rack, Someplace else?_____

SAMARITAN COUNSELING CENTER

Name:	**Date:**
DOB:	**Age:**

Summary of Adult Symptom Screening – Please answer ALL questions

Over the last **2 weeks**, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Feeling down, depressed, or hopeless				
Little interest or pleasure in doing things				
Feeling nervous, anxious or on edge				
Not being able to stop or control worrying				

The following questions relate to your experiences over the last **6 months**:

	Yes	No
In the past 6 months, did you ever have a spell or an attack when all of a sudden you felt frightened, anxious or very uneasy?		
In the past 6 months, did you ever have a spell or attack when for no reason your heart suddenly began to race, you felt faint, or you couldn't catch your breath?		
Did any of these spells or attacks ever happen in a situation when you were not in danger or not the center of attention?		

Please respond to the degree that the following problems have bothered you during **the past week.**

	Not at all	A little bit	Somewhat	Very much
Fear of embarrassment causes me to avoid doing things or speaking to people.				
I avoid activities in which I am the center of attention.				
Being embarrassed or looking stupid are among my worst fears.				

Please answer each question to the best of your ability.

	Yes	No
Have you experienced any of the following traumatic events: natural disaster (e.g., flood, hurricane, tornado, earthquake), fire, explosion, or industrial accident; transportation accident (e.g., car accident, plane crash); physical assault (e.g., being attacked, beaten up); sexual assault (e.g., rape, attempted rape, made to perform any type of sexual act through force or threat of harm); captivity or exposure to a war-zone; life-threatening illness or injury; sudden, unexpected death of or injury to someone close to you; or serious injury, harm, or death to someone else that you witnessed or caused?		
Has this event caused any significant problems or symptoms that lasted for more than a month?		

SAMARITAN COUNSELING CENTER

Please answer each question to the best of your ability.

Has there ever been a period of time when you were not your usual self and...	**Yes**	**No**
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?		
...you were so irritable that you shouted at people or started fights or arguments?		
...you felt much more self-confident than usual?		

Has there ever been a period of time when you were not your usual self and...	**Yes**	**No**
...you got much less sleep than usual and found you didn't really miss it?		
...you were much more talkative or spoke much faster than usual?		
...thoughts raced through your head or you couldn't slow your mind down?		
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?		
...you had much more energy than usual?		
...you were much more active or did many more things than usual?		
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?		
...you were much more interested in sex than usual?		
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?		
...spending money got you or your family into trouble?		

The following questions relate to your **eating habits**:

	Yes	**No**
When you eat, do you make yourself sick because you feel uncomfortably full?		
Do you ever worry that you have lost control over how much you eat?		
Have you recently lost more than 14 pounds in a 3 month period?		
Do you believe yourself to be fat when others say you are too thin?		
Would you say that food dominates your life?		

	Yes	**No**
Have you ever been bothered by having to perform some ritual or act over and over that does not make sense?		

The following questions relate to your **alcohol and substance use:**

		Never (Skip the next 2 questions)	**Monthly or less**	**2 to 4 times a month**	**2 to 3 times a week**	**4 or more times a week**
How often do you have a drink of Alcohol?						
		1 to 2	**3 to 4**	**5 to 6**	**7 to 9**	**10 +**
How many drinks containing alcohol do you have on a typical day when you are drinking?						

	Never	**Less than monthly**	**Monthly**	**Weekly**	**Daly or almost daily**
How often do you have six or more drinks on one occasion?					

	Yes	No
In the past year have you used an illegal drug or used a prescription medication for non-medical reasons?		

Please answer the questions below, rating yourself on each of the criteria shown using the scale provided. As you answer each question, select the option that best describes how you have felt and conducted yourself over the past **6 months**.

	Never	Rarely	Sometimes	Often	Very Often
How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
How often do you have difficulty getting things in order when you have to do a task that requires organization?					
How often do you have problems remembering appointments or obligations?					
When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
How often do you feel overly active and compelled to do things, like you were driven by a motor?					

The questions listed below relate to your thoughts and feelings. If the way you have been in recent weeks or months differs from the way you usually are, please answer based on when you were **your usual self**.

	Yes	No
Do you find that most people will take advantage of you if you let them know too much about you?		
Do you generally feel nervous or anxious around people?		
Do you avoid situations where you have to meet new people?		
Do you avoid getting to know people because you're worried that they may not like you?		
Has avoidance of getting to know people due to fear of being disliked affected the number of friends that you have?		
Do you keep changing the way you present yourself to people because you don't know who you really are?		
Do you often feel like your beliefs change so much that you don't know what you really believe any more?		
Do you often get angry or irritated because people don't recognize your special talents or achievements as much as they should?		
Have you had any unusual experiences such as hearing voices, seeing visions, or having ideas you later found out were not true?		
Have you had any other experiences, such as mind reading, ESP, thoughts being controlled by others, seeing things on TV that refer to you specifically?		

Please complete and return to:
Samaritan Counseling Center
3001 E. Main St.
Endwell, NY 13760

***NOTE: you will not be contacted if all forms are not complete!**

Anything else you would like us to know?