Samaritan Counseling Centers of the Mid-South

REGISTRATION FORM

Today's Date: ____/____/_____

		Age	Sex	Date of Birth
Clients Full Name:				
Spouse/Partner/ Parents if child:				
Children/Siblings or others in the household:				

Clients Address	**City**	**State**	**Zip**

Cell Phone	**Home Phone**	**Work Phone**	**Other Phone**

Email:

May a telephone message be left for you at these numbers? □ Yes □ No ***Details:*** **_____**
Do you want to receive SCC event information/ Newsletters? □ Yes □ No **If yes, please provide your Email address.**

Emergency Contact & Phone Number:

EMPLOYMENT		
Employers	**Address**	**Phone**

EDUCATION		
Schools Attended	**Degreee earned?**	**Date**

REFERAL INFORMATION
We like to acknowledge and thank members of the professional community for their trust in referring persons to us. Will you give us permission to make such contact by phone or letter? If so, please sign below.
Name of Referring Individual:
Address and/or Phone Number:
Your Signature:

(Optional) RELIGIOUS PREFERENCE		
Religious Preference?	Worship Home:	
Is religion or spirituality important to you? □ Yes □ No	Please explain:	

FINANCIAL INFORMATION

THIRD PARTY RESPONSIBLE FOR PAYMENT (if other than insurance or client named on page one)		
Name & Address of Person/Agency/Church	**Cell Phone**	**Other Phone**

INSURANCE INFORMATION
Do you have Insurance**? □Yes □No** Secondary Insurance**? □Yes □No** (W**rite secondary info on back)** **Your counselor will make a copy of your insurance card and ID.**
Insurance Company:
ID Number:
Group Number:
We file insurance as a courtesy to you. By signing and dating below you authorize the release of your information to process your claims and to authorize payment of benefits to Samaritan Counseling Centers of the MidSouth.
I, the undersigned certify that I (OR MY DEPENDENT**) have insurance coverage with (**NAME OF INSURANCE COMPANY**) _____ and assign all insurance benefit payments, if any, directly to The Samarian Counseling Centers of the Mid-South. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize The Samaritan Counseling Centers of the Mid-South to release all information necessary to secure the payment of insurance benefits. I authorize the use of this signature on all insurance submissions.** **Responsible Party Signature: X_____Date_____**

ADJUSTED FEE ASSISTANCE (SLIDING SCALE)	
The fee for counseling is $135 per session. Supplemental support may be available for people with financial need. *If you are requesting fee assistance (sliding scale); this section below must be completed in full.	
***# of People in Household:**	***Total Annual Household Income:**
***Savings:**	***Other Income:**

FINANCIAL AGREEMENT (MUST BE COMPLETED AND SIGNED WITH YOUR THERAPIST)	
(Check all that apply) □ **Insurance -** $135 □ **EAP** (how many?)_____ □ **Self Pay/Third Party Fee** _____ □ **Adjusted Fee/Sliding Scale(*Must have fee assistance section above filled out to use sliding scale)** _____	
I/We agree to the payment of this fee as services are rendered, including late cancellations (less than 24 hours' notice) and "no shows" as designated in policies of the counseling center. I also understand that I will be responsible for any and all deductibles, coinsurance, and copays.	
Signed: X	Date:
Signed: X	Date:
Counselor Signature: X	Date:

Clinic Use Only:

Designated Client(s):	**File Ins/EAP?** □ Yes □ No	**Clinician:**
	DX:	**Site:**
		***Fee:**
*OS Fee explained:		
Clinical Lead Approval Signature:_____ Date:_____		

GENERAL INFORMATION

RELATIONSHIP STATUS
□ Single □ Married □ Partnered □ Separated □ Divorced □ Widowed □ Engaged

TYPE OF COUNSELING SOUGHT
□ Individual □ Couple □ Family □ Group □ Child □ Evaluation □ _____

MEDICAL & MENTAL HEALTH		
Primary Physician	**Address**	**Phone**

Please list any current medical conditions and treatments (including prescription, over-the-counter, herbal, etc.)

Medical Condition/Concern	Medication/Treatment	Dosage/Frequency

Are you currently seeing a psychiatrist, or other counselor/therapist? □ Yes □ No

Name	Address	Phone

Have you ever received psychological, psychiatric, or counseling services before? □ Yes □ No

When? From/To	Clinician/Therapist/Agency	Reason for Treatment	Results

Have you ever taken medications for emotional or psychiatric problems? □ Yes □ No

When?	Prescribing Physician	What Medication?	For What?	Results

WHY ARE YOU SEEKING OUR HELP?:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

PATIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) have created new patient 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 applies to all health care providers, including mental health care, and providers. Health care agencies throughout the country are now required to provide patients a notification of their privacy rights as it relates to their health care records.

We will provide for you a document to inform you of your rights in a simple yet comprehensive fashion: *My Patient Notification of Privacy Rights.* In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship, and as such, we will do all we can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask for clarification.

By law, Samaritan Counseling Centers of the Mid-South, Inc. is required to secure your signature indicating you have received this Patient Notification of Privacy Rights Document.

I understand and have been provided a copy of Patient Notification of Privacy Rights Document, which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgment form.

Date

X (**PRINT** NAME) / /

Date

X (**SIGN** NAME) / /

Patient Signature or Parent if Minor or Legal Charge

If Legal Charge, describe representative authority: _____

GUIDELINES, UNDERSTANDINGS, AND INFORMED CONSENT

CONSENT FOR TREATMENT: By signing below, I agree that I have read and understand the information provided for me in the *Guidelines and Understandings*, and that I am agreeing to work with my counselor in the counseling process. I understand that if I choose to use my insurance, the Center can supply the necessary information to my insurance company, including diagnosis and treatment information. I understand that I am responsible for any outstanding payments for services received; that I am aware of the 24-hour cancellation policy; and that I am aware of the Center's policy to contact me by mail and telephone for payment of fees and completion of evaluations. I am giving my consent to the above terms.

Client's signature **X**_____ date _____

Counselor's signature **X**_____ date _____

SAMARITAN COUNSELING CENTERS OF THE MID SOUTH

COMMUNICATION BY EMAIL, TEXT MESSAGE, AND OTHER NON-SECURE MEANS

It may become useful during the course of treatment to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. Be informed that these methods, in their typical form, are not confidential means of communication. If you use these methods to communicate with your therapist at Samaritan Counseling Center, there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages
- Your employer, if you use your work email to communicate with your therapist at Samaritan Counseling Center.
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

If there are people in your life that you don't want accessing these communications, please talk with your therapist at Samaritan Counseling Center about ways to keep your communications safe and confidential.

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I consent to allow Samaritan Counseling Centers of the Mid-South to use unsecured email and mobile phone text messaging to transmit to me the following protected health information:

- Information related to the scheduling of meetings or other appointments
- Information related to billing and payment
- Completed forms, including forms that may contain sensitive, confidential information
- Information of a therapeutic or clinical nature, including discussion of personal material relevant to my treatment
- My health record, in part or in whole, or summaries of material from my health record
- Other information. Describe: _____

BY THE FOLLOWING NON-SECURE MEDIA:
Check all that apply:

☐ Voice mail.

☐ Unsecured email.

☐ SMS text message (i.e. traditional text messaging) or other type of "text message."

☐ Other media. Describe: _____.

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

_____ _____

Signature of client Date

CLIENTS COPY

Samaritan Counseling Centers of the Mid-South

35 S. Auburndale St.; Memphis, Tennessee 38104
901-729-3900; FAX: 901-729-2737

Guidelines, Understandings, and Informed Consent

We are an interfaith, non-profit agency offering a ministry of healing to those seeking a balance of emotion, relational, and spiritual health. We provide an environment of compassion and confidentiality where your feelings, values, and ideas are honored.

APPOINTMENTS & FEES: Appointments are made through your counselor. The regular fee for a 50-60 minute session with one therapist is $135, although you may request an adjustment if you need help with the fee and you are not using insurance. The counselor will work with you, if necessary, to adjust the fee to your circumstances. Payment (check, cash, VISA or MasterCard) is requested at each session unless otherwise arranged with your counselor.

CANCELLATION POLICY: Your counselor reserves a full hour of time for you. He or she cannot reasonably fill a missed or late-canceled appointment without adequate notice. Hence, the agreed upon session *fee will be charged for appointments not canceled 24 hours in advance.*

TELEPHONE AND EMERGENCIES: Each counselor can be reached through the Center's number, which, if you leave a message, will be returned as soon as possible. We do not provide on-call or in-patient services, so in case of emergency, call the Crisis Hotline, 274-7477, 9-1-1, or go the nearest Emergency Room.

CONFIDENTIALITY: All information shared in therapy is confidential with the following exceptions:

1. When you have given consent for your therapist to talk to another mental health professional or any other person;
2. Cases of imminent physical harm to self or others;
3. Suspicion of child abuse or abuse of an impaired adult, as required by Tennessee law;
4. When an agent of a court of law compels the disclosure of information.

All of our staff members and volunteers abide by our confidentiality policy. We will file insurance claims but cannot be held accountable for your insurance company's confidentiality procedures, nor can we insure complete confidentiality when required to transmit your information by facsimile or other electronic means.

COUNSELING PROCESS, BENEFITS, AND RISKS: Psychotherapy depends on cooperation and honest dialog between you and your counselor. Although it can help with self-awareness, better communication, reducing conflict, and altering distressing moods, there may also be periods of unpleasantness. There are no guarantees of outcome, and you have the right to stop at any time; however, we recommend a closure session before termination or counselor changes, and you will be responsible for payment of services already received.

YOUR COUNSELOR IS: _____

COUNSELORS CONTACT INFORMATION: _____

NEXT APPOINTMENT IS: _____

DETAILS: _____