Samaritan
HEALING MIND, BODY, SPIRIT

# ADULT CLIENT INFORMATION FORM

*This information will be treated confidentially and only used by your counselor. Please try to answer each question.*

**Name:** _____ **DOB:** _____ **Age:** _____ **Race/Ethnicity:** _____

**Gender (Birth Sex):** _____ **Gender Identity (optional):** _____ **Pronouns:** _____

**Marital Status**: ☐ Single ☐ Partner ☐ Married ☐ Divorced ☐ Widowed

If partner/married, please rate your relationship: ☐ Very Happy ☐ Happy ☐ Unsure ☐ Unhappy

Partner/Spouse name: _____ DOB: _____

Address: _____ Phone: _____

Partner's/Spouse's occupation and employer: _____ Phone: _____

Is partner/spouse willing to come for counseling? ☐ Yes ☐ No ☐ Uncertain

Date of partner/marriage: _____ Ages when partner/married: Client: _____ Partner/Spouse: _____

How long did you know your partner/spouse before relationship/marriage? _____

Are you currently separated or in the process of divorce? ☐ No ☐ Yes

If divorced/separated, when? _____ Reason for divorce/separated: _____

Previous partners/marriages: Dates _____ Reason(s) for relationship/marriage ending: _____

Concerns: _____ If widowed, when? _____

**Children** *List all children (full/half/adoptive/foster). If more children, please inform counselor.*

| Name | Age | Sex | Living (Yes/No) | Partner/Married (Yes/No) | From prev. marriage? (Yes/No) |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**Parents**

Were you raised by your biological parents? ☐ Yes ☐ No If not, by whom? _____

Are your parents living? ☐ Father ☐ Mother If living, ages of: Father _____ Mother _____

Living together? ☐ Yes ☐ No Were your parents divorced? ☐ Yes ☐ No Your age? _____

Did one or both die during your childhood? ☐ Yes ☐ No Your age? _____

Rate your parent's marriage: ☐ Unhappy ☐ Average ☐ Happy ☐ Very Happy

Rate your childhood: ☐ Unhappy ☐ Average ☐ Happy ☐ Very Happy

Rate your adult life: ☐ Unhappy ☐ Average ☐ Happy ☐ Very Happy

As a child did you feel closer to your: ☐ Father ☐ Mother ☐ Another parent figure: _____

Ethnic heritage: Father _____ Mother _____ Religious preference: Father _____ Mother _____

Education (years): Father _____ Mother _____ Occupation: Father _____ Mother _____

**Brothers and Sisters** *In birth order, including yourself (so we know where you fit). If more, please inform counselor.*

| Name | Age | Sex | Living (Yes/No) | Marital Status | Children Status |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Describe your current relationship with your parents and/or siblings: _____

**Health**

Rate your physical health: ☐ Very Good ☐ Good ☐ Average ☐ Declining ☐ Poor

Height: _____ Weight: _____ Recent weight changes? ☐ Loss ☐ Gain

Sleep: ☐ No Trouble ☐ Have trouble ☐ Please explain: _____

Date of last physical exam:_____ List significant medical conditions: _____

Are you currently taking medication? ☐ No ☐ Yes If yes, list them:_____

Have you ever had a "nervous breakdown" or been severely emotionally upset? ☐ Yes ☐ No

Have you ever been physically abused? ☐ Yes ☐ No Have you ever been sexually abused? ☐ Yes ☐ No

Have you had previous counseling? ☐ Yes ☐ No Facility/Therapist:_____ When? _____

**Addictions**

Has alcohol, drugs, or gambling ever been a problem? ☐ You ☐ Spouse ☐ Parents ☐ Siblings ☐ Other family:_____

In a few words, describe the problem(s):_____

Has your social life, work life, or relationships changed due to drugs, alcohol, or gambling? if so, please explain:

Have you or anyone in your family ever had an eating disorder? If so, please specify:_____

**Education**

Highest Grade Completed: High School: _____ College (Where):_____ Other: _____

Are you a Veteran or in the Military: ☐ No ☐ Yes If yes: Branch? _____

Years of Service:_____ Wartime duty? _____

**Occupation**

Employer:_____ Job Title: _____

Other Training (type and years): _____

Have you changed jobs recently? ☐ No ☐ Yes Reasons for the change: _____

**Legal History**

Briefly describe involvements, at any time, with the legal system, including dates, reasons, and results:

**Preferred Spirituality or Religious Fellowship** (i.e. church, mosque, temple, or other spiritual community)

Do you participate in a faith community? ☐ No ☐ Yes

Worship community:_____ Location: _____

Attendance per month: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+ Childhood religious affiliation: _____

What would you like your counselor to know regarding your spiritual/religious experiences or needs?

**Life Experiences**

List three significant events in your life and how they were significant:

_____

_____

_____

What Your Main reason for this Visit? Who Suggested you seek Counseling? _____

_____

_____

Please select any of the following issues that concern you…

- ☐ abuse: emotional, physical, sexual
- ☐ academics (grades, performance)
- ☐ addictions in your family
- ☐ alcohol and/or drugs
- ☐ anger needs for control
- ☐ anxiety, worry, nervousness
- ☐ concentration
- ☐ cultural adjustment
- ☐ decision-making
- ☐ delusions
- ☐ depression, mood swings
- ☐ doom (overwhelming sense of)
- ☐ eating, appetite, food intake
- ☐ fatigue, tiredness
- ☐ finances
- ☐ forgetfulness
- ☐ gambling
- ☐ grief, loss, death
- ☐ guilt, shame
- ☐ hallucinations
- ☐ helplessness
- ☐ hopelessness
- ☐ irritability
- ☐ learning disability
- ☐ legal issues
- ☐ living situation
- ☐ medical issues
- ☐ motivation
- ☐ muscle tension
- ☐ obsessions, compulsions
- ☐ pain (chronic)
- ☐ panic attacks
- ☐ paranoia
- ☐ phobias, fears
- ☐ pregnancy
- ☐ procrastination
- ☐ racing thoughts
- ☐ rape, sexual assault
- ☐ relationships
- ☐ spirituality, religion
- ☐ self-esteem, self-confidence
- ☐ self-injury: cutting, burning, suffocating
- ☐ sexual orientation and/or identity issues
- ☐ sexuality issues
- ☐ social discomfort, anxiety, isolation
- ☐ stress management
- ☐ suicidal thoughts, death wishes
- ☐ suicide attempts
- ☐ tearfulness
- ☐ time management
- ☐ unemployment
- ☐ weight, body image
- ☐ work, job
- ☐ worthlessness

Briefly describe any of the above issues further: _____

_____

_____

How long have these concerns been an issue for you? _____

_____

_____

What are your goals for counseling? What do you hope to gain from counseling? _____

_____

_____

*CONFIDENTIAL: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.*

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# FEE AGREEMENT FOR PROFESSIONAL SERVICES

TO BE COMPLETED BY RESPONSIBLE PARTY/LEGAL GUARDIAN/INSURED

**Client Information** *(if minor enter their information below)*

Name: _____ DOB: _____

Social Security Number: _____ *Used for insurance purposes only*

Primary Address _____ City/State/Zip: _____

Main Phone: _____ Can we leave a message? ☐ Yes ☐ No

Email address_____ Employer_____

**Person Responsible for Payment** *(if different from Client)*

Name: _____ DOB: _____

Social Security Number: _____ *Used for insurance purposes only*

Primary Address: _____ City/State/Zip: _____

Main Phone: _____ Can we leave a message? ☐ Yes ☐ No

Email address_____ Relationship to client: _____

Please select and initial **ONE** option to indicate your chose method for payment:

**INSURANCE (Commercial, Medicaid, Medicare):**

_____ I wish to use my insurance and request that Samaritan bill my insurance company for fees. I am aware that I will be responsible for deductibles or co-payments/co-insurance required by my policy as well as charges not covered by my insurance plan. Co-payments are required at the time of the services. Billing statements are sent out monthly and are expected to be paid in full within 30 days. If my insurance company denies payment of fees for any reason, I agree to make payment of the fees in full. Samaritan will submit claims to your insurance company as a courtesy to you, but as the insured, I acknowledge that I am responsible for all fees incurred for services provided for myself and/or my dependents.

**SELF-PAY/FEE FOR SERVICE:**

_____ If you do not want to use your insurance or Samaritan is not in your plan, you will be billed directly for services provided to you. We accept credit, cash, or checks.

**COURT ORDERED:**

_____ Please note that if you are recommended to Samaritan by an attorney or the courts for services, often times the insurance company will not cover those charges, so we will ask for full payment at the time of service. No reports will be submitted to the attorneys or courts until all fees are paid in full.

**REQUEST FOR FINANCIAL ASSISTANCE:**

_____ Samaritan may be able to offer reduced fees to uninsured clients because of the financial contributions of area churches, organizations and individuals. If you have requested to be considered for a reduced fee based on your ability to pay, a fee worksheet will be attached to this agreement. ***You are required to pay this fee at the time of services.***

**Address changes:** You are expected to notify us immediately of changes in address, phone numbers, insurance coverage, etc. Failure to notify Samaritan of changes to insurance will result in an expectation of you paying the charges incurred. Insurance companies generally do not allow back billing.

**Fees for Minors:** In the case of minors, the parent that signs the fee agreement is responsible for payment. As it relates to custody it is the parents' responsibility to come to an agreement related to payment of any account balance.

**Late Cancellation** and **No-Show fee:** If you do not keep a scheduled appointment or do not notify Samaritan at least 24 hours in advance to cancel a scheduled appointment, Samaritan has the right to charge a $70.00 fee that must be paid prior to being seen again. This can be paid by credit card or cash in the office. Any future appointments that are scheduled may be cancelled to allow other clients to be seen. Upon payment of the no show charge, you may again resume scheduling an appointment. There may be some conditions based on payer types where someone might be placed on a "same day" appointment policy. A third no show will result in termination of care.

**Insurance Information** *(needed if using insurance as payment method)*

**Please fill out below and provide a copy of the front and back of your insurance card(s) at first appointment.**

**Primary Insurance:** _____ Phone: _____

Subscriber name: _____ DOB: _____

Member ID: _____ Group #: _____

Client is (check one): ☐ Subscriber ☐ Spouse of subscriber ☐ Child of subscriber

**Secondary Insurance:** _____ Phone: _____

Subscriber name: _____ DOB: _____

Member ID: _____ Group #: _____

Client is (check one): ☐ Subscriber ☐ Spouse of subscriber ☐ Child of subscriber

*If tertiary or additional insurance, please inform our client benefit specialists.*

**Other Payor Information**

Name: _____ Relationship to client: _____

Phone: _____ Email:

_____

Billing address: _____

Check one: ☐ 1. Will pay for ALL sessions ☐ 2. Will pay for _____ sessions ☐ 3. Will pay for a portion of each session

If you selected option 2 or 3, please specify: _____

The standard therapy session is 45 minutes. Additional billable services may include brief sessions held in-person, via phone, or telehealth, sessions with a family member without client present, and sessions with the client and family member(s) present. Initial intake sessions are 50 minutes.

I hereby authorize Samaritan to furnish the above-named insurance company(ies) or other named parties responsible for payment with information requested and necessary for payment of services provided. I further authorize payment directly to Samaritan for services provided. I am further aware that failure to pay, may result in action taken to collect my fees, and that in doing so, Samaritan will be disclosing that I have received services at their agency.

_____ _____

Signature of Responsible Person Date

What made you choose Samaritan?

_____

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# ORIENTATION TO OUTPATIENT COUNSELING

## Client responsibilities

Appointment times are reserved especially for you. If you are unable to attend a scheduled appointment, you need to cancel or reschedule that appointment 24 hours before your scheduled time. For your convenience, our telephones are answered 5 days per week- during office/front desk business hours Mon, Tues, and Thurs 8am-5pm, Wed 8am-4pm, Fri 8am-2pm or after hours feel free to leave a message. You are responsible to be on time for your appointments. Failure to do so may result in your appointment being rescheduled. You may be denied further appointments or charged a fee after having missed an appointment without proper notice. Samaritan may terminate you from services for failure to attend scheduled appointments.

All clients are expected to communicate in a respectful manner to all Samaritan staff and to refrain from verbal threats, physical harm to personnel, clients or property of Samaritan. Weapons of any kind are not allowed on the premises.

You are expected to attend all sessions alcohol and/or drug free.

Please discuss any questions or concerns about your treatment with your Therapist. If this does not resolve the matter, ask to speak to the Clinical Director at 920-866-9319.

Parents/Guardians of minors are expected to accompany the child to each appointment. For safety reasons an adult must supervise any children in the waiting area at all times.

## Client Rights

*Confidentiality*

Information shared by clients during sessions is confidential, and you (and/or your legal guardian if you are under 14 years) must give written permission to share information with others, ***except in the following circumstances:***

- There is a threat of harm to yourself or others.
- You report an incident of physical, emotional or sexual abuse or neglect of a child, or you report sexual activity and you are under the age of 18.
- Parents or legal guardians of children younger than 18 years of age can request information from the client file.
- You are on Samaritan premises and need immediate medical attention.
- Your records are ordered by a Judge through a court order.
- Disclosure to another health care Therapist-treatment facilities may release limited information without written consent to a health care Therapist under certain circumstances. This information may be released without consent under DHS 51.30 (8).
- You may be asked to sign releases of information. These may be revoked at any time but must be done in writing.

*Emergency Services*

Emergency services can be obtained after hours by contacting 911, your local county crisis intervention line, or SAMARITAN at 920-886-9319. An emergency is one that is considered to be **life or death** and you feel that you need immediate assistance from a therapist.

I hereby attest that I understand the expectations written above and I agree to uphold my responsibilities. Further I attest that I have been offered a HIPAA packet, and the Client Rights Brochure.

_____ _____
Client signature (14 years and older) Date

_____ _____ _____ _____
Parent/Legal Guardian Signature Date Parent/Legal Guardian Signature Date

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# INFORMED CONSENT –Treatment Services (HSS 94.03)

Samaritan is sensitive to the spiritual and faith-based resources that some people want to use as they explore health and well-being. We welcome opportunities to integrate a client's spiritual belief and practices as a part of the therapeutic process. Therapists will not impose their personal belief upon our clients, rather if requested, we work with the belief system of the clients and include discussion of spirituality/religion/faith according to the expressed preference.

**PROBABLE BENEFIT OF TREATMENT:** If you do not think your needs are being met, you are urged to discuss this with your therapist. This discussion will provide the opportunity to clarify goals or consider the possibility of a referral to another therapist who may better meet your needs.

**SIDE EFFECTS OF TREATMENT/Probable consequences of not receiving treatment:** The treatment process typically involves identifying and talking about issues that are difficult or painful. It is not unusual to feel like things are getting worse before you feel progress or improvement. Not receiving treatment will include the possibility you will continue to experience similar problems or things may get worse.

**PROVIDERS OF TREATMENT:** Services are provided by Licensed Masters level Therapists, Master level Therapist-Residents holding a training license provided by the State of Wisconsin, or Master's Level Counseling Interns who are in good standing with their academic university. All Clinical Therapists and their cases are reviewed and supervised by a Clinical Director and/or Supervisor as well as a consulting Clinical Psychologist. Alcohol and Drug services are provided by dual licensed therapist with a specialty in AODA and supervised by an AODA Clinical Supervisor. Samaritan is a training site for Master's level students (interns) in training for counseling and social work. With your permission, one of these interns may be present with your counselor during appointments. Including trainees in your appointments have the added benefit of having more feedback and ideas for your counseling; however, you retain the right to deny the inclusion of trainees.

**ALTERNATIVE TREATMENT:** Alternative modes of treatment will be discussed during the assessment process, and/or during the course of treatment planning.

**RELEASE OF INFORMATION FOR BILLING PURPOSES:** I agree that the organization may release to and receive from any insurers, other payers, or other persons, necessary for billing and related purposes. This information may include my identity, diagnosis and prognosis, treatment for mental health and/or alcohol or drug issues and all other information contained in my record to the extent that such records are needed for billing or collection of benefits. I am aware that I have the option to pay for services at the time of my sessions.

**TIME PERIOD OF INFORMED CONSENT/RIGHT TO WITHDRAW:** Your consent for treatment will last until the goals of treatment have been satisfactorily reached, or you or your therapist elects to terminate treatment. This consent will be renewed every 12 months. You retain the right to withdraw informed consent and terminate treatment at any time. We do ask that you discuss this with your therapist.

**NO SHOW:** Be aware that if you miss an appointment Samaritan has the right to charge a fee and all future appointments already scheduled will be cancelled to make time available for other clients. If you no show or late cancel for more than two appointments Samaritan Counseling may terminate services.

My signature below indicates that my therapist has explained this informed consent and I am satisfied with my understanding of the treatment process and have been offered a copy of this document. I hereby voluntarily consent to be actively involved in treatment.

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| Client Signature | Date | Parent/Guardian Signature | Date |
| _____ | _____ | _____ | _____ |
| Therapist Signature | Date | Parent/Guardian Signature | Date |

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# FORM CONSENT TO VIDEOTHERAPY[1]

## Introduction

"**VideoTherapy Services**" involves the delivery of health care services[2] using electronic communications, information technology or other means between a health care provider employed by or otherwise contracted with SAMARITAN ("**Provider**") and a client who are not in the same physical location. VideoTherapy may be used for diagnosis, treatment, follow-up and/or education, and may include, but is not limited to:

- Electronic transmission of clinical records, photo images, personal health information or other data between a member and a Provider;
- Interactions between a client and Provider via audio, video and/or data communications; and
- Use of output data from clinical devices, sound and video files.

The vendor of the electronic systems used in the provision of VideoTherapy Services has represented that it incorporates industry standard network and software security protocols to protect the privacy and security of health information.

## Possible Benefits of VideoTherapy

- Can be easier and more efficient for you to access clinical care and treatment from a Provider.
- You can obtain clinical care and treatment at times that are convenient for you.
- You can interact with a Provider without the necessity of an in-office appointment.

## Possible Risks of VideoTherapy

- Information transmitted to your Provider may not be sufficient to allow for appropriate clinical decision making by the Provider.
- The inability of your Provider to conduct certain tests or assessments in-person may in some cases prevent the Provider from providing a diagnosis or treatment or from identifying the need for emergency clinical care or treatment for you.
- Your Provider may not able to provide clinical treatment for your particular condition via VideoTherapy and you may be required to seek alternative care.
- Security protocols or safeguards could fail causing a breach of privacy.
- Given regulatory requirements in certain jurisdictions, your Provider's treatment options may be limited.
- Delays in clinical evaluation/treatment could occur due to failures of the video technology.

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[1] Please note that individual states may have additional and specific requirements for consent to video-conference based therapy including but not limited to special requirements related to the provision of mental health treatment and the confidentiality of such information. As a result, the sample provided above is intended only as a guide.

[2] Consider further defining health care services ("including but not limited to") based upon the types of therapy provided by the Center.

By accepting this Consent to VideoTherapy, you acknowledge your understanding and agreement to the following:

1. I understand that the delivery of health care services via VideoTherapy is an evolving field and that the use of VideoTherapy in my clinical care and treatment may include uses of technology not specifically described in this consent.
2. I understand that while the use of VideoTherapy may provide potential benefits to me, as with any clinical care service no such benefits or specific results can be guaranteed. My condition may not be cured or improved, and in some cases, may get worse.
3. It is my duty to inform my Provider of other in-person or electronic interactions regarding my care that I may have with other health care providers.
4. I understand that my Provider may determine in his or her sole discretion that my condition is not suitable for treatment using VideoTherapy, and that I may need to seek clinical care and treatment in-person or from an alternative source.
5. A variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My Provider has explained the alternatives to my satisfaction.
6. I understand that the same confidentiality and privacy protections that apply to my other health care services also apply to these VideoTherapy services.
7. I agree and authorize my Provider and Center to share information regarding the VideoTherapy exam with other individuals for treatment, payment and health care operations purposes as allowed by law.
8. I understand that I can withhold or withdraw my consent at any time by emailing or providing other such written notification to my Provider with such instruction, without affecting my right to future care or treatment. Otherwise, this consent will be considered renewed upon each new VideoTherapy consultation with my Provider.

**Client Consent To The Use of VideoTherapy**

I have read this special Consent to VideoTherapy carefully, and understand the risks and benefits of the use of VideoTherapy in the course of my treatment. I have discussed it with my Provider, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of VideoTherapy in my medical care.

I hereby authorize Provider to use VideoTherapy in the course of my diagnosis and treatment.

_____ _____

Client Signature (or person authorized to sign for client) Date

Client Name:_____

If authorized signer, relationship to client: _____

_____ _____

Therapist Signature Date

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# HIPAA Email Consent Form

When Samaritan sends you an email, or you send Samaritan an email, the information that is sent is not encrypted. This means there is a risk that a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it

Under the Health Insurance Portability and Accountability Act (HIPAA), if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive personal health information via email, a provider may send that patient personal medical information via unencrypted email.

Please select an option from below:

☐ OPTION 1 – **ALLOW** UNENCRYPTED EMAIL
I understand the risks of unencrypted email and hereby give permission to Samaritan to send me personal health information (PHI) via unencrypted email.

☐ OPTION 2 – **DO NOT ALLOW** UNENCRYPTED EMAIL
I do not wish to receive personal health information via email.

_____ _____
**Client or Guardian Signature** **Date**

_____
**Please Print email address (ONLY FOR OPTION 1)**

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# Demographic Information

Samaritan is a United Way funded agency. United Way seeks to provide services to underserved populations in our community. Minorities and those living in poverty are less likely to seek out support. The information we gather on this form helps us to identify whether we are meeting the needs of all our community members. Thank you for taking the time to provide this information.

**Client's Age**

☐ 0-3 ☐ 4-5 ☐ 6-12 ☐ 13-18 ☐ 19-21 ☐ 22-39 ☐ 40-59 ☐ 60-79 ☐ 80+

**Client's Gender**

☐ Female ☐ Male ☐ Other ☐ n/a

**Client's Race**

☐ American Indian/Alaskan Native
☐ Black/African-American
☐ Asian
☐ Caucasian/White
☐ Hawaiian/Pacific Island
☐ Multiple Races
☐ Other/Unknown
☐ n/a

**Client's Ethnicity**

☐ Hispanic/Latinx (Cuban, Mexican, Puerto Rican, South or Central American. People of Hispanic/Latinx origin can be of any race.)
☐ Hmong
☐ Other……
☐ Unknown
☐ n/a

**Client's Geographic Location by Zip Code**

☐ 54911 Appleton
☐ 54912 Appleton
☐ 54913 Appleton
☐ 54914 Appleton
☐ 54915 Appleton
☐ 54922 Bear Creek
☐ 54106 Black Creek
☐ 54110 Brillion
☐ 54113 Combined Locks
☐ 54931 Dale
☐ 54123 Forest Junction
☐ 54131 Freedom
☐ 54942 Greenville
☐ 54944 Hortonville/Medina
☐ 54130 Kaukauna
☐ 54136 Kimberly
☐ 54947 Larson
☐ 54140 Little Chute
☐ 54952 Menasha
☐ 54956 Neenah
☐ 54152 Nichols
☐ 54165 Seymour
☐ 54169 Sherwood
☐ 54170 Shiocton
☐ 54557 Winchester
☐ Other……

**Client receives free or reduced lunch at school.** ☐ **Yes** ☐ **No**

**Client's previous annual household income based on family size (if exceeds please leave blank):**

| 1 person | 2 persons | 3 persons | 4 persons | 5 persons | 6 persons | 7 persons | 8 persons |
|---|---|---|---|---|---|---|---|
| ☐ 15,700 | ☐ 17,950 | ☐ 20,150 | ☐ 22,400 | ☐ 24,200 | ☐ 26,000 | ☐ 27,800 | ☐ 29,600 |
| ☐ 26,150 | ☐ 29,900 | ☐ 33,600 | ☐ 37,350 | ☐ 40,350 | ☐ 43,350 | ☐ 46,300 | ☐ 49,300 |
| ☐ 41,850 | ☐ 47,800 | ☐ 53,800 | ☐ 59,750 | ☐ 64,550 | ☐ 69,300 | ☐ 74,100 | ☐ 78,900 |