SAMARITAN COUNSELING CENTER (SCC)

FEE AGREEMENT FOR PROFESSIONAL SERVICES

Client Information
Name ____ DOB ______/______/_______
Social Security Number ______-_____-_______ *Used for insurance purposes only*
Address __________________________________City_______________________State ______ Zip_______
Phone: Home ____________________ Cell:______________________
Employer____
Email address____________________________________ Can we leave a message? Yes _____No____

Person Responsible for Payment/Insurance *(if different from Client)*
Name ____ DOB ______/________/_______
Social Security Number _______-______-______
Address ______________________________City_______________________State ______ Zip______
Phone: Home:______________________ Cell:_____________________
Employer____
Relationship to client ____

The standard therapy session is 45 minutes.

Please initial where indicated

INSURANCE:
_______ I wish to use my insurance and request that Samaritan Counseling Center 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. SCC 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.

FEE FOR SERVICE:
_______ If you do not want to use your insurance or SCC 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 SCC 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 Counseling Center 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.***

Late Cancellation and **No Show fee:** If you do not keep a scheduled appointment or do not notify SCC at least 24 hours in advance to cancel a scheduled appointment, Samaritan Counseling Center 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.

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.

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

I hereby authorize Samaritan Counseling Center 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 Counseling Center 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 Counseling Center will be disclosing that I have received services at their agency.

____ ________________________

Signature of Responsible Person Date

What made you choose Samaritan Counseling Center?

____

SAMARITAN COUNSELING CENTER (SCC)

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 normal business hours (9am-5pm) 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 Counseling Center may terminate you from services for failure to attend scheduled appointments.

All clients are expected to communicate in a respectful manner to all Samaritan Center staff and to refrain from verbal threats, physical harm to personnel, clients or property of Samaritan Counseling Center. 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 Counseling Center 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 SCC 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

SAMARITAN COUNSELING CENTER (SCC)

INFORMED CONSENT –Treatment Services (HSS 94.03)

SCC 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 or Master level Therapist-Residents holding a training license provided by the State of Wisconsin. 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.

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 SCC has the right to charge a fee and all future appointments already scheduled will be cancelled to make time available for other client's. 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

SAMARITAN COUNSELING CENTER OF THE FOX VALLEY
INFORMATION FORM

Parents of Children and Adolescents

Parents: Please complete this form. This information will be treated confidentially and will be helpful to your child's counselor. Please try to answer each question.

Child's Name ____ Sex M __ F __ Age ____ Birth Date ____/____/____

Mother's Name____ Age_____ Birth Date____/____/____ Nationality___________
Father's Name____ Age_____ Birth Date____/____/____ Nationality___ _______
Legal Guardian(s)____ Age_____ Birth Date____/____/____
Address____Telephone (H)_______________(W)___________________
Step Parent's name and address_____________ ____
Step Parent's name and address____

Parents:
Single___ Married___ Divorced ___ Widowed___
If married, please rate your marriage as . . . Very Happy ___ Happy ___ Unsure ___ or Unhappy ___
Date of marriage __________ Ages when married: Wife _____ Husband _____
Are you currently separated _____ or in the process of divorce _____?
Is spouse/family willing to come for counseling? Yes ___ No ___ Uncertain ___
If divorced, when? __________ Reason for divorce ____
If widowed, when? _________ Concerns ____
Previous marriages: Dates _______________ Reason(s) for marriage ending ____
Dates _______________ Reason(s) for marriage ending _______ ____
Education: (years) Father _____ Mother _____
Employment: Father____________________________________Mother____
Have you changed jobs recently? Reasons for the change _______ ____
Religious preference: Father _________ Mother _________
Other adults significant in my child's life____

Other Children
Check(3) if child is by previous marriage or stepchild. If more than four children, use the back of this form
3 Name Age Sex (F or M) Living (Yes or No)
Education (Years) Married (Yes or No)
____
____
____
____

Health
Rate your child's 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 ______________ ___________________________
Is your child presently taking medication? If so, what? ____
Has your child ever had a "nervous breakdown" or been severely emotionally upset? Yes ___ No ___
Has your child ever been physically abused? Yes ___ No ___ Sexually abused? Yes ___ No ___
Has your child had previous counseling? Yes ___ No ___ Facility and therapist ___________________________________
When ______________________Issues addressed____

Addictions
Has alcohol, drugs, or gambling ever been a problem? You ___ Spouse ___ Children___Grandparents ___Other__________________
In a few words, describe the problem(s) ____
Has your or your child's social life, work life, or relationships changed due to drugs, alcohol, or gambling? (Explain)_____ ________
____
Has your child or anyone in your family ever had an eating disorder? If so, please specify ___________________________________ _

- Over -

Developmental History

Child's Prenatal History:

Were there any conception or fertility problems?____
Has mother had any miscarriages, still births, or abortions?__________________________________
Was this a planned pregnancy?____
Were there any complications during the pregnancy?____
Were there any stressors during the pregnancy?____
Did mother take medications, use alcohol or drugs, or smoke during the pregnancy? Please specify __________________
____
Any complications with labor and delivery?____

Child's Infancy and early childhood:

How was this child as an infant (quiet, colicky, easy, predictable, etc.)?___________________________________
____
When did your child walk?____________________Talk__________________________Toilet Train__________________________
How did/does you child handle separations?____
Is or was your child in daycare or sittercare?____

Child's Temperament:

Rate your child's activity level: Extremely Active Very Active Active Quiet Inactive
Have there been any significant changes in your child's activity level?____
____
Rate your child's attention span: Engrossed Long 10 ----- 5 ----- 1 Short Not able to engage
How does your child respond to new people and situations?____
____
How sensitive is your child to noise, visual stimuli, rough clothing, and other sensation?__________________________________
____
How does your child express happiness?___________________________________Sadness?__________________________________
Anger?____
Who in the family is your child most like?____
What are your child's strengths?____
What are your child's weaknesses?____

Child's Educational, Vocational, and Legal History:

Grade Completed: (circle) P K 1 2 3 4 5 6 7 8 9 10 11 12 +
School ________________________ Teacher __________________________ School Counselor________________________________ Does your child receive special education services?__________ Why?____ Family Military History: if none ___ Branch and Years of Service ____ Briefly describe family involvement, at any time, with the legal system, including dates, reasons, and results)_____________________
____
Probation Officer ____________________________ Telephone_________________________

Family Religious Background:

Church _________________________________ Denomination __________________________ Location ___________________________
Church attendance per month (circle) 0 1 2 3 4 5+
Explain any recent changes in your religious life and/or past remarkable religious experiences __________________________________
____

I am concerned about my child right now because ____
____
____
____

Please (✖) any of the following issues that concern you…

___abuse: emotional, physical, sexual
___academics (grades, performance)
___addictions in your family
___aggression
___alcohol and/or drugs
___anger
___anxiety, worry, nervousness
___avoidance
___behavioral problems
___childhood harm to animals/others
___complains of sickness a lot
___concentration
___cultural adjustment
___decision-making
___delusions
___depression, mood swings
___detachment/estrangement
___difficulties listening
___doom (overwhelming sense of)
___eating, appetite, food intake
___family relationships
___fatigue, tiredness
___finances
___forgetfulness
___gambling
___grief, loss, death
___guilt, shame
___hallucinations
___helplessness
___homicidal thoughts
___hopelessness
___irritability
___isolation
___learning disability
___legal issues
___living situation
___medical issues
___motivation
___muscle tension
___ need for control
___obsessions, compulsions
___pain (chronic)
___panic attacks
___paranoia
___peer relationships
___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
___sleep disturbances
___social discomfort, anxiety, withdrawal
___stress management
___suicidal thoughts, death wishes
___suicide attempts
___tearfulness
___time management
___trauma
___unemployment
___weight, body image
___work, job
___worthlessness

Briefly describe any of the above issues further…____
____
____
____

How long have these concerns been an issue?
____
____

What are the goals for counseling? What do you hope to gain from counseling?
____
____
____
____
____

Revised 09/17