

Instructions for Completing Intake Paperwork

Welcome to Samaritan Center of Puget Sound. Please take a few minutes to complete the following paperwork in this packet before you meet with your therapist.

Client Information

Complete one of these forms for yourself. Each additional person is to complete his/her own.

Insurance Information (two sides)

If you have insurance that you hope will help cover the cost of our service, please fill out the Insurance Information form, front and back, and sign it twice in the spaces provided. If you are meeting your therapist in our Main Office, ask the support staff to make and hand you a photocopy, front and back, of your insurance card for you to add to this packet. Although the information requested on the Insurance form appears redundant to what is on your insurance card, it is important that you complete the form entirely. If you are unsure about how to complete the Insurance form, ask your therapist to assist you during your appointment.

Questions to Ask Your Insurance Provider

Listed are questions for you to ask your insurance provider, as needed—typically by calling the 800 number on your insurance card, or by looking at their website.

Fee Agreement (two copies – one for you and one for Samaritan)

You may have clarified your fee with your therapist via phone prior to this session, or it may be set at the first session. Please read and sign at the bottom of both copies. Each additional person is to do the same.

Note: If you do not plan to use insurance, write your initials in the space provided on both copies. Each additional person is to do the same. Your therapist will sign and return your copy.

Notice of Privacy Practices (one copy for you)

You may read this now or later after your first session. Please keep it for your records.

Disclosure Statement (two copies – one for you and one for Samaritan) --Not yet available online

Please read this, print your name in the space for 'client name,' then sign and date once above and below where indicated on the last page. If you are coming with others, have them read and double-sign the last page as well. Repeat this for the second copy. Your therapist will sign and return your copy.

EAP Information (Employee Assistance Program)

If you are using your workplace Employee Assistance Program, complete the top half of this form and double-sign and date it. Otherwise, write "NA" at the top.

When you are finished completing this packet, please keep it in your possession and hand it to your therapist when s/he meets you.

Thank You.

Samaritan Center

CLIENT INFORMATION
For Confidential Use Only

Client Legal Name _____ Today's Date _____

Address _____
Street name and number City, State, Zip Code E-Mail Address

Birthdate _____ Occupation _____ Employer/School _____

Home Phone _____ Work Phone _____ Cell Phone _____
Leave Message? ___Yes ___No Leave Message? ___Yes ___No Leave Message? ___Yes ___No

Name/Address of Financially Responsible Party (for minors or anyone using 3rd party, non-ins. payor) _____

If Client Is a Minor: Name/Address/Phone of custodial parent, if different from name above: _____

Emergency Contact _____
Name and phone number

CURRENT COUPLE STATUS

- Single
- Engaged
- Married
- Prev. Marr.(s) # _____
- Partnered/cohabiting
- Separated
- Divorced
- Widowed

Date(s): _____

RELIGIOUS PREFERENCE

- Christian
 - Presbyterian
 - Other Protestant
 - Roman Catholic
- Jewish
- Muslim
- Buddhist
- Other _____
- Not Affiliated

RACE/ETHNICITY

- African American
- Asian American
- European American
- Latin American
- Native American
- Other _____

GENDER

- Female
- Male

Name of church or place of worship: _____ # Years Education _____

Check if spirituality is important for you to have addressed or included in your therapy.

Gross Annual Family Income: \$ _____ /year Number Dependent on Income: _____

Family and Household Members (includes housemates, spouse, partner, children; continue on back if needed). Clarify if client is a minor from two households (include any different last names).

Name	Age	Sex	Relationship	Living with you?
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Physician's Name _____ Phone _____ Date of last exam _____

Physician's Address _____

It is our practice to coordinate care with one's physician when this would be helpful. If you agree that we may contact your physician, please check here: (Please sign a release of information form for this purpose.)

List any surgeries or illnesses you have had the past five years: (Continue below if needed.) _____

List any medications with the amount you are currently taking, or have taken in the past 3 months:(Continue on below if needed.)

PLEASE CONTINUE ON NEXT PAGE....

For confidential use only

Have you had previous counseling/therapy? Yes No

If yes, when? _____ Name of Therapist(s) _____

Reason/issue? _____

Please state your purpose in coming to Samaritan. (Continue below if needed.) _____

Name and address of person who referred you to Samaritan _____

Relationship to you: _____

May we send a Thank You? (If yes, please initial.) _____ Please add me to the Samaritan mailing list. Yes No

FOR THERAPIST USE ONLY

Therapist: _____ Branch: _____ Initial Session Code: _____ 90801 Fee: _____ 90806/47 Fee: _____ Date: _____

Referral Source: Return Direct Desk

Payment: Ins* Wom/Men/Yth (requires application from therapist) EAP 3rd Party Non-insurance Guarantor (i.e., church) Self-pay

* Insurance Information Form must be completed, double-signed by client, stapled to photocopy of medical card and turned in with Intake packet
 Check if insurance paperwork and/or photocopy of medical card is forthcoming

File: Ind Cpl/Fam >> if Cpl/Fam, check one: Primary client ('patient' for insurance; contact for scheduling) Additional client

Case #: _____

INSURANCE INFORMATION

Client: First Name _____ M.I. _____ Last Name _____

Social Security # _____ Birth Date ____________ Gender: M___ F___

Marital Status: Single _____ Married _____ Other _____

Employment Status: Employed _____ Full-Time Student _____ Part-Time Student _____

Is patient's Condition Related to: Employment _____ Auto Accident _____ Other Accident _____ State in which occurred _____

If there is a specific injury or illness which precipitated coming for counseling:

Date of current injury or illness ____________ Date of same or similiar condition ____________

Work lost due to current condition from ____________ to ____________

Hospitalization due to current condition from ____________ to ____________

Client or Authorized Person's Signature:

Insured or Authorized Person's Signature- I authorize payment of medical benefits to Samaritan Center of Puget Sound..

Signed _____ **Date** _____

I authorize the release of any medical or other information necessary to process this claim or any further claims. I also request payment of government benefits either to myself or to the party who accepts assignment below.

Signed _____ **Date** _____

To be completed by therapist

Therapist: _____

Provider Number: _____

Prior authorization number (if required): _____

Diagnosis: _____

Which procedure codes (CPT) will be billed? _____

In which office will this client be seen? _____

FOR OFFICE USE ONLY:

_____ Network
Coverage _____ Client Co-Pay _____
_____ Client %
_____ Deductible
_____ # of Sessions
_____ Payment %
Referral: _____ None Needed
_____ P.C. Physician
Authorization: _____ None Needed
_____ Regence
_____ Value-Options
_____ UBH

Effective Date: _____
Other _____

Name of Customer Service Rep: _____

Authorization #: _____

of Sessions Auth. _____

Authorization Date From: _____

Exclusions: _____

Comments: _____

Insurance Information -

Client Name _____

Client Number _____

Insurance Company Information -- Primary Coverage

Policy Holder Information:

First Name _____ M.I. _____ Last Name _____

Address _____

City _____ State _____ Zip _____

Home phone _____ Work phone _____

Birth Date ____________ Gender: male ____ female ____

Client relationship to Insured: Self ____ Spouse ____ Child ____ Other ____

Under employer's health plan? *Circle one* Y N Insured's Soc. Sec.# _____

Employer Name _____

Insurance Plan _____

Ins Co. Name _____ Phone number _____

Address _____

City _____ State _____ Zip _____

ID number _____

Policy number _____ Group number _____

Insurance Company Information -- Secondary Coverage

If there is another health benefit plan, complete the following.

Other Insured Information:

First Name _____ M. I. _____ Last Name _____

Birth Date ____________ Gender: male ____ female ____

Client relationship to Insured: Self ____ Spouse ____ Child ____ Other ____

Under employer's health plan? Y N Insured's Soc. Sec. # _____

Employer Name _____

Insurance Plan _____

Ins Co. Name _____ Phone number _____

Address _____

City _____ State _____ Zip _____

Phone number _____

ID number _____

Policy number _____ Group number _____

Questions to Ask Your Insurance Provider Concerning Mental Health Benefits

Do I have behavioral or mental health coverage?

Do I need to have a referral from my Primary Care Physician?

Do I need to have pre-authorization from the insurance company?

Am I only authorized to see a particular kind of therapist? (Psychiatrist, Psychologist, Licensed Mental Health Counselor, Licensed Marriage and Family Therapist, Licensed Clinical Social Worker, etc.)?

Am I limited to a certain number of sessions of therapy (per fiscal year, calendar year)?

What is the effective date of insurance coverage?

Am I limited to a dollar amount per year (\$500, \$250) that will be covered?

What is my deductible and co-pay after insurance adjustment is applied?

If I am authorized to see one therapist and that does not work out, do I need to get authorization for a different therapist?

Fee Agreement

Appointments

Counseling sessions are normally 45-50 minutes in length, including rescheduling and payment. Consistency in keeping appointments is important to the counseling process. When canceling or rescheduling an appointment, 24 hours notice is expected at minimum. If clients are unable to provide timely notice or miss an appointment, they will be charged the full amount for the session.

Samaritan Fee Policies

The standard fee for a counseling session at Samaritan is \$135 for psychologists and \$120 for all other psychotherapists. A client who does not have the means to pay the standard fee may qualify for an adjusted fee as provided by Samaritan's fee adjustment schedule. This is made possible by subsidies from the greater community or the agency.

A client's fee-per-session is determined at the first session, or beforehand via telephone. Because additional administrative and clinical staff time is required to set up a new client account and treatment plan, a one-time first-session-fee (which is 1.5 times the regular fee-per-session) is charged to cover the first session.

Payment in full (or payment of one's deductible and/or co-pay, in the case of insurance) should be given to the counselor at the beginning of each session. The fee-per-session may be adjusted up or down if financial circumstances change. If a client's account becomes more than two sessions past due, the counselor will not be able to schedule additional appointments until payments are current.

During the course of treatment if a client requests additional services such as (but not limited to) phone consultations, reports, correspondence or the copying of records, prorated charges will apply.

Client Agreement to Pay for Service

I agree to pay all charges for services that I incur. If I use insurance to cover some or all of my counseling at Samaritan, I agree to pay any amounts that my insurance carrier does not pay. These may include, but are not limited to, services and charges determined by my insurance carrier not to be medically necessary, and/or services and charges not covered by my insurance plan. If I incur a charge for a missed or late-canceled appointment, I understand that I will be responsible for payment of the agreed-upon fee per session. The following are my agreed-upon fees:

Fee-Per-Session: \$ _____ **First-Session-Fee:** \$ _____

My/Our initials here _____ indicate I/we do not plan to use insurance.

I/we have read, understand, and agree to the above.

Client(s) Signature _____

Date _____

Therapist Signature _____

Fee Agreement

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I/we have read, understand, and agree to the above.

Client(s) Signature _____

Date _____

Therapist Signature _____

Health Insurance Portability & Accountability [HIPAA] Privacy Practices

This notice tells you how we make use of your health information at our Center, how we might disclose your health information to others, and how you can get access to the same information.

Please review this notice carefully and feel free to ask for clarification about anything in this material you might not understand. The privacy of your health information is very important to us and we want to do everything possible to protect that privacy.

We have a legal responsibility under the laws of the United States and the state of Washington to keep your health information private. Part of our responsibility is to give you this notice about our privacy practices. Another part of our responsibility is to follow the practices in this notice.

This notice takes effect on April 14, 2003 and will be in effect until we replace it.

We have the right to change any of these privacy practices as long as those changes are permitted or required by law.

Any changes in our privacy practices will effect how we protect the privacy of your health information. This includes health information we will receive about you or that we create here at Samaritan Center of Puget Sound. These changes could also effect how we protect the privacy of any of your health information we had before the changes.

When we make any of these changes, we will also change this notice and give you a copy of the new notice. When you are finished reading this notice, you may request a copy of it at no charge to you.

If you request a copy of this notice at any time in the future, we will give you a copy at no charge to you.

If you have any questions or concerns about the material in this document, please ask us for assistance which we will provide at no additional charge to you.

Here are some examples of how we use and disclose information about your health information. Section I: Permissible uses and disclosures without your written authorization.

We may use or disclose your health information without your written authorization, excluding Psychotherapy Notes as described in Section II, for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law.

1. To your physician or other healthcare provider who is also treating you.
2. To anyone on our staff involved in your treatment program.
3. To any person required by federal, state, or local laws to have lawful access to your treatment program.
4. To receive payment from a third party payer for services we provide for you.
5. To our own staff in connection with our Center's operations. Examples of these include, but are not limited to the following: evaluating the effectiveness of our staff, supervising our staff, improving the quality of our

services, meeting accreditation standards, and in connection with licensing, credentialing, or certification activities.

6. To your physician or other healthcare provider who is also treating you.
7. To anyone on our staff involved in your treatment program.
8. To any person required by federal, state, or local laws to have lawful access to your treatment program.
9. To receive payment from a third party payer for services we provide for you.
10. To our own staff in connection with our Center's operations. Examples of these include, but are not limited to the following: evaluating the effectiveness of our staff, supervising our staff, improving the quality of our services, meeting accreditation standards, and in connection with licensing, credentialing, or certification activities.
11. To a family member, a person responsible for your care, or your personal representative in the event of an emergency. If you are present in such a case, we will give you an opportunity to object. If you object, or are not present, or are incapable of responding, we may use our professional judgment, in light of the nature of the emergency, to go ahead and use or disclose your health information in your best interest at that time. In so doing, we will only use or disclose the aspects your health information that are necessary to respond to the emergency.
12. When required or permitted to do so by law. For example, to appropriate authorities if your therapist reasonably believes that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition, to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access your health information; disclosures to judicial and law enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; and disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions or otherwise as authorized by law
13. We will not use your health information in any of our Center's marketing, development, public relations, or related activities without your written authorization. We cannot use or disclose your health information in any ways other than those described in this notice unless you give us written permission.

Section II

With written permission: We may use or disclose your health information to anyone you give us written authorization to have your health information, for any reason you want. You may revoke this authorization in writing anytime you want. When you revoke an authorization it will only effect your health information from that point on.

Psychotherapy Notes: Notes recorded by your therapist documenting the contents of a counseling session with you ("Psychotherapy Notes") are not part of your health information. They will be used only by your therapist and will not otherwise be used or disclosed without your written authorization.

As a client of Samaritan Center of Puget Sound, **you have these important rights:**

- A. With limited exceptions, you can make a written request to inspect your health information that is maintained by us for our use.

- B. You can ask us for photocopies of the information in part “A” above.
- C. We will charge you \$0.10 per page for making these photocopies.
- D. You have a right to a copy of this notice at no charge.
- E. You can make a written request to have us communicate with you about your health information by alternative means, at an alternative location. (An example would be if your primary language is not spoken at this Center, and we are treating a child of whom you have lawful custody.) Your written request must specify the alternative means and location.
- F. You can make a written request that we place other restrictions on the ways we use or disclose your health information. We may deny any or all of your requested restrictions. If we agree to these restrictions, we will abide by them in all situations except those which, in our professional judgment, constitute an emergency.
- G. You can make a written request that we amend the information in part “A” above.
- H. If we approve your written amendment, we will change our records accordingly. We will also notify anyone else who may have received this information, and anyone else of your choosing.
- I. If we deny your amendment, you can place a written statement in our records disagreeing with our denial of your request.
- J. You may make a written request that we provide you with a list of those occasions where we or our business associates disclosed your health information for purposes other than treatment, payment, or our Center’s operations. This can go back as far as six years, but not before April 14, 2003.
- K. If you request the accounting in “J” above more than once in a 12 month period we may charge you a fee based on our actual costs of tabulating these disclosures.
- L. If you believe we have violated any of your privacy rights, or you disagree with a decision we have made about any of your rights in this notice you may complain to us in writing to the following person:

Compliance Officer:	Address
William K. Collins, Ph.D., M.S. Telephone: (206) 526-2266 Fax: (206) 527-1009 E-mail: BCollins@samaritanps.org	Samaritan Center of Puget Sound 564 NE Ravenna Blvd. Seattle, WA 98115

- M. You may also submit a written complaint to the United States Department of Health and Human Services. We will provide you with that address upon written request.

Terms Important in Understanding the HIPAA Privacy Rule

Health Information:

Any information, whether oral or recorded in any form, created or used by health care professionals or health care entities.

Individually Identifiable Health Information: A subset of Health Information that either identifies the individual or that can be used to identify the individual.

Protected Health Information (PHI)

Individually Identifiable Health Information becomes Protected Health Information when it is transmitted or maintained in any form or medium. More specifically, PHI is information that relates to the past, present or future physical or mental health condition of an individual; or the past, present or future payment for the provision of health care to individual; and that identifies the individual or could reasonably be used to identify the individual.

Psychotherapy Notes

Notes recorded in any medium by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or group, joint or family counseling session, and that are separated from the rest of the individual's medical record.

Use and Disclosure

The privacy rule defines "use" as the sharing, employment, application, utilization, examination or analysis of individually identifiable health information within an entity that maintains such information.

The privacy rule defines a "disclosure" as the release, transfer, provision or access to, or divulging in any other manner of information outside the entity holding the information.

The definition of the privacy rule specifically excludes information pertaining to medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests and any summary of the following: diagnosis, functional status, the treatment plan, symptoms, prognosis and process to date.



The **Disclosure Statement** form of your therapist is currently not available on our website. Two hardcopies (one for you and one for Samaritan) will be available for you to sign and date at your first session.



EAP Information
(Employee Assistance Program)

Client:

First Name _____ Last Name _____

Social Security # _____ Birth Date ____ \ ____ \ ____

Gender: Male _____ Female _____

Marital Status: Single _____ Married _____ Other _____

I authorize the release of any medical or other information necessary to process this claim or any further claims.

_____ Date _____

Client or Authorized Person's Signature

I authorize payment of EAP benefits to Samaritan Center of Puget Sound.

_____ Date _____

Insured or Authorized Person's Signature

EAP Information: To Be Completed by Therapist

Therapist Bills _____ Office Bills _____

Number of sessions authorized: _____ Authorization Dates: From _____ to _____

Authorization Number: _____

Client Relationship to Insured: Self _____ Spouse _____ Child _____ Other _____

EAP Company: _____

EAP Address: _____

Phone Number: _____

Employer Name: _____

Therapist: _____

Diagnosis: _____