

Samaritan Counseling Centers, Inc.
 340 Commerce Square
 Michigan City, Indiana 46360
Billing Information Form/New Clients

COUNSELOR USE	
COUNSELOR: _____	GAF: _____
Dx Code: _____	FF__INS__FS\$__

Thank you for choosing Samaritan Counseling Center. Please complete the information below to help our billing process be efficient and accurate. We abide by the HIPPA privacy standards in our billing practices. Our billing services are managed by Samaritan Interfaith - Naperville, Illinois.

First	MI	M/F
Client's Name:	Gender:	Today's Date: / /
Home Address:	City	State Zip
*Home Phone # ()	*Cell Phone # ()	
*Spouse/Parent/Other Phone # ()	Employer:	
*Initial if Ok to Leave Messages at the Numbers Provided.		
Date of Birth: ____/____/____	Social Security Number: ____-____-____	Marital Status: Single ____ Married ____ Separated ____ Divorced ____ Widowed ____
Age: ____	Ethnic Background: African American ____ Asian American ____ Caucasian ____ Hispanic ____ Other: ____	

Please list all names related to billing on this account:

Name	Age	Date of Birth	Gender	Occupation/Employer

WHO IS RESPONSIBLE FOR THIS ACCOUNT? Name: _____ Date of Birth: _____
 Social Security Number (if different from number provided above): ____-____-____
 Address/Phone (if different from client name above): _____

WILL YOU BE USING INSURANCE? Yes No **IF YES, PLEASE LET US PHOTOCOPY YOUR INSURANCE CARD.**

Patients or Authorized Persons Signature -
 > I authorize the release of any medical or other information necessary to process this claim.
 > I authorize payment of medical benefits to Samaritan Interfaith for services rendered.
 > **I ACCEPT THE FINANCIAL RESPONSIBILITY OF ANY BALANCE REMAINING ON ACCOUNT AFTER INSURANCE HAS PROCESSED THE CLAIM.**

PLEASE SIGN _____ DATE _____

CANCELLATION & RETURN CHECK POLICIES

- * Because counseling hours are reserved, Samaritan Counseling Centers charges for canceled sessions when less than 24 hours notice is given. The missed appointment charge is \$30.00.
- * There will be a \$20.00 service charge on all returned checks.
- * I am aware that I may pay with cash, check, or credit card

I understand the policies as stated above. Signature _____ Date _____

Optional Information that assists our research for grant applications:

Do you attend church/place of worship now? Church Name _____ City _____

Which of the following categories best describes your household's total income before taxes last year? Please include from all sources such as salaries and wages, Social Security, retirement income, investments, and other sources	_____ Less than \$20,000	_____ \$20,000 - \$39,999
	_____ \$40,000 - \$59,999	_____ \$60,000 - \$79,999
	_____ \$80,000 - \$99,999	_____ \$100,000 or more

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Fee Subsidy Application

The following information is required when a fee subsidy greater than that suggested by our guidelines is requested, or if you are using health insurance and are requesting a fee subsidy.

Your Name: _____ **Today's Date:** _____

1. What are you reasons for requesting a fee subsidy at this time?

- ____ I do not have health insurance and cannot afford the normal fee.
- ____ I do have health insurance but do not want to use it at this time.
- ____ My mental health benefits have been exhausted.
- ____ My mental health copay is greater than I can afford to pay.
- ____ My health insurance plan has large deductible requirements.
- ____ My insurance does not cover services by Samaritan Counseling Centers, Inc.

2. Do you have a Health Savings Account or Flex Spending Account? Yes _____ No _____

3. What is your family income each month (include all income - salary, pension, child support, public aid, etc.): \$ _____ Please provide proof of income.

4. What was your total family income last year? \$ _____

5. Do you expect major changes in your income in the near future? If so, please explain:

6. How many people do you support with your income? _____

6. Are there other major demands on your income such as college tuition payments, nursing home costs, etc.? If so, please list: _____

7. What other factors would you like us to consider in your request for a fee subsidy? _____

(Your Signature)

(For Office Use Only)

A fee of \$ _____ per counseling session, requiring a fee subsidy of \$ _____ per session, will be in effect for _____ sessions.

(counselor signature)

(date)

Executive Director Approval If Fee Below Guidelines: _____
(initials)

(date)

Parents/Step Parents and Guardians (Specify)

Name	Relation	Living	Where	Deceased	When

EDUCATION:

Indicate last grade completed or degree(s) earned:

School	Grade or Degree	Date

Other Training: _____

Have you been in military service? Yes No Dates: _____

Served in combat? Yes No _____

MEDICAL INFORMATION

Your Doctors' names: (Primary): _____

(Specialist): _____ Specialty: _____

(Specialist): _____ Specialty: _____

(Specialist): _____ Specialty: _____

Last time you saw a physician: Date: _____ Reason for visit _____

Dates and Reasons for Hospitalization (if any)

Date Admitted	Date Discharged	Reason for Hospitalization	Hospital's Name

List any other significant illnesses or injuries: _____

List any allergies you have: _____

Name: _____

Family's Medical History (Check if present in your parents, brothers, sisters)

	Myself	Parent	Brother Sister		Myself	Parent	Brother Sister
Stroke				Diabetes			
Heart Problems				Cancer			
High Blood Pressure				High Cholesterol			
Mental Disorders				Other:			

PERSONAL HABITS:

	Yes	No	Frequency	Type	Dates of use or Amount
Drug Use					
Alcohol Use					
Prayer/meditation					
Smoking					
Eating Concerns					
Restricted Diet					
Sleeping Concerns					
Caffeine Use					
Exercise					

YOUR EMOTIONAL HEALTH:

	Yes	No	Date	Therapist/Psychiatrist Name & Address	For How Long
Have you had previous counseling or psychotherapy?					
Are you presently seeing another therapist?					
Have you ever been treated or seen by a psychiatrist?					
Have you been hospitalized for mental health reasons?					

Have you had suicidal thoughts or feelings? Past Current Attempted Planning

Name: _____

CONCERNS:

State in your own words the concerns you bring to counseling: _____

Check the items that describe or relate to the concerns mentioned above:

- | | | |
|--|---|--|
| <input type="checkbox"/> Death in family | <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Loss of faith in others |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Loss of hope |
| <input type="checkbox"/> Depression or Sadness | <input type="checkbox"/> Relationship with parents | <input type="checkbox"/> Loss of meaning |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Relationship with children | <input type="checkbox"/> Loss of self respect |
| <input type="checkbox"/> Religious doubts or fears | <input type="checkbox"/> Relationship with partner | <input type="checkbox"/> Loss of love |
| <input type="checkbox"/> Guilt | <input type="checkbox"/> Self doubt | <input type="checkbox"/> Self injurious behavior |
| <input type="checkbox"/> Sexual concerns | <input type="checkbox"/> Fear | <input type="checkbox"/> Anger Management issues |
| <input type="checkbox"/> Lack of interest in sex | <input type="checkbox"/> Anger with God | <input type="checkbox"/> Addiction Type: |
| <input type="checkbox"/> Sexual orientation | <input type="checkbox"/> Loss of faith in self | _____ |
| <input type="checkbox"/> Infidelity | <input type="checkbox"/> Loss of faith in God | _____ |
| | | Other _____ |

Presently I believe: (Check One)

	Poor	Fair	Average	Good	Excellent
My Physical Condition is					
My Emotional Condition is					
My Spiritual Condition is					

Client's Signature

Date

Parent's Signature If Minor

Date

Therapist's Signature

Date reviewed

PLEASE FILL OUT THE REST OF THE FORMS IN THIS PACKET

Burns Depression Checklist*

Check how much each of the following 15 symptoms has been bothering you in the past several *WEEKS/months*.

	0 - NOT AT ALL	1 - SOMEWHAT	2 - MODERATELY	3 - A LOT
1. Sadness: Have you been feeling sad or down in the dumps?				
2. Discouragement: Does the future look bleak or hopeless?				
3. Low self-esteem: Do you feel worthless or think of yourself as a loser?				
4. Inferiority: Do you feel inadequate or inferior to others?				
5. Guilt: Do you get self-critical and blame yourself?				
6. Indecisiveness: Is it hard to make decisions?				
7. Irritability and frustration: Have you been feeling angry or resentful?				
8. Loss of interest in life: Have you lost interest in your career, hobbies, family, or friends?				
9. Loss of motivation: Do you feel overwhelmed and have to push yourself hard to do things?				
10. Poor self-image: Do you think you're looking old or unattractive?				
11. Appetite changes: Have you lost your appetite? Or, do you overeat compulsively?				
12. Sleep changes: Is it hard to get a good night's sleep? Are you tired and sleeping too much?				
13. Loss of libido: Have you lost your interest in sex?				
14. Hypochondriasis: Do you worry a lot about your health?				
15. Suicidal impulses: Do you think life is not worth living or think you'd be better off dead?***				

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** Anyone with suicidal urges should seek immediate help from a mental health professional.

Name _____ Date _____

Burns Anxiety Inventory*

Instructions: Check how much each of the following 33 symptoms has been bothering you in the past several years.

	0 - NOT AT ALL	1 - SOMEWHAT	2 - MODERATELY	3 - A LOT
CATEGORY I: ANXIOUS FEELINGS				
1. Anxiety, nervousness, worry or fear				
2. Feeling things around you are strange or foggy				
3. Feeling detached from all or part of your body				
4. Sudden unexpected panic spells				
5. Apprehension or a sense of impending doom				
6. Feeling tense, stress, "uptight, or on edge				
CATEGORY II: ANXIOUS THOUGHTS				
7. Difficulty concentrating				
8. Racing thoughts				
9. Frightening fantasies or daydreams				
10. Feeling on the verge of losing control				
11. Fears of cracking up or going crazy				
12. Fears of fainting or passing out				
13. Fears of illnesses, heart attacks or dying				
14. Fears of looking foolish in front of others				
15. Fears if being alone, isolated or abandoned				
16. Fears of criticism or disapproval				
17. Fears that something terrible will happen				

(OVER)

Name _____

Date _____

Burns Anxiety Inventory*

Instructions: Check how much each of the following 33 symptoms has been bothering you in the past several years.

CATEGORY III: PHYSICAL SYMPTOMS

	0 - NOT AT ALL	1 - SOMEWHAT	2 - MODERATELY	3 - A LOT
18. Skipping , racing or pounding of the heart				
19. Pain, pressure or tightness in the chest				
20. Tingling or numbness in the toes or fingers				
21. Butterflies or discomfort in the stomach				
22. Constipation or diarrhea				
23. Restlessness or jumpiness				
24. Tight, tense muscles				
25. Sweating not brought on by heat				
26. A lump in the throat				
27. Trembling or shaking				
28. Rubbery or "jelly" legs				
29. Feeling dizzy, lightheaded or off balance				
30. Choking or smothering sensations				
31. Headaches or pains in the neck or back				
32. Hot flashes or cold chills				
33. Feeling tired, weak or easily exhausted				

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