Samaritan Counseling Centers, Inc.

CLIENT REGISTRATION

To help you have the best possible treatment please fill out all information as completely as you are able. This information, along with any other information will be kept confidential. Thank you.

Demographic Information

Name: _____

Date of Birth: _____ Age: _____

Address: _____

Phone Number : _____ Ok to leave message: Yes___ or No___
Mobile Number : _____ Ok to text message: Yes___ or No___

Email Address: _____ Ok to send message: Yes___ or No__

Race/Ethnicity: _____ Gender: _____

Sexual Orientation: _____ Religious/Spiritual Affiliation: _____

Relationship status: _ Married __Divorced __Separated __Widowed __Single __Serious Dating/Committed

__Civil Union/Domestic Partnership/or equivalent

Highest Level of Education: _____ Are you currently a student? __ Yes or __No

School(s):_____

Degree(s):_____

Employment Status: ___ Employed Full Time ___Employed Part Time __Unemployed ___ Retired ___Disabled
___Student ____ Other: _____

Have you been in military service? ___ Yes ___ No Dates: _____
Served in combat? ____ Yes ____ No Locations and date: _____

Current Living Arrangements: _____

Do you currently require handicap accessibility? ___ Yes or ___No

Emergency Contact Information

Name: _____ Relationship:_____

Phone: _____

I consent that you may contact this person in case of emergency: _____Yes ____No
_____(Sign for consent to contact above named person)

Referral Information

Who referred you for services? _____

Insurance Information

Responsible Party's Name: _____ Date of Birth: _____

Address: _____ Phone No. _____

Employer: _____ Employer Phone Number: _____

Primary Insurance: _____ Policy No. _____ Group No _____

Secondary Insurance: _____ Policy No. _____ Group No. _____

Patient's relationship to the responsible party: _____

Medical Information

Primary Care Physician: _____ Phone: _____

Specialist:_____ Specialty:_____

I consent for you to share information about my case with my PCP ____Yes ____No
_____(Signature consenting to share information with PCP)

Current Medication (Include Dosage and Prescriber): _____
_____
_____

_____

_____(use back of sheet if needed)

Is current medication useful? _____

Current Medication side effects? _____

Medical Conditions: (e.g., seizures, MS, Stroke, heart disease, heart attack, cancer, hypertension, diabetes, liver disease, kidney disease, fibromyalgia, chronic fatigue, etc.) _____

_____

_____

_____

Any injury resulting in loss of consciousness or brain injury (please include dates)? _____

_____

List any allergies you have: _____

_____

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/Location

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

Concerns:

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

_____

_____

_____

_____

NOTICE OF SAMARITAN COUNSELING CENTERS, INC. PRIVACY PRACTICES

The 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 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 Indiana 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 affect 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 Counseling Centers, Inc. These changes could also affect 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 have any questions or concerns about the material in this document, please ask us for assistance which we will provide at no charge to you.

_____
(Client's Name in Print)

_____ _____
(Client's Signature) (Date)

_____
(Signature of Parent or Guardian of Minor Client)

Important Information about Confidentiality

We may use or disclose your health information:

a. To your physician or other healthcare provider who is also treating you. However, it is our policy to obtain your written permission before conferring with any healthcare professional unless it is an emergency.

b. To anyone on our staff involved in your treatment program.

c. To any person required by federal, state, or local laws to have lawful access to your treatment program.

d. To receive payment from a third party payer for services we provide for you.

e. To our own staff 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 connections with licensing.

f. 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.

g. In the event of any emergency, to a family member, a person responsible for your care, or your personal representative. 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 of your health information that are necessary to respond to the emergency.

h. We will abide by required applicable state laws governing abuse, neglect, criminal activities, threats to the health/safety of the client and others, domestic violence, etc.

i. We will abide by any state laws related to the Health Insurance Portability and Accountability Act of 1996 and its revisions that went into effect on April 14, 2003.

j. We cannot use or disclose your health information in any way other than those described in this notice unless you give us written permission.

Client's Rights

As a client of Samaritan Counseling Centers, Inc., **YOU** have these important rights:

2. With limited exceptions, you can make a written request to inspect your health information that is maintained by us for our use. There are differences between access to psychotherapy records and psychotherapy notes.

3. You can ask us for photocopies of the information of the notice of privacy practices.

4. We will charge you a reasonable charge per page for making these photocopies.

5. You have a right to a copy of this notice at no charge.

6. 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 in the Center, and we are treating a child of whom you have lawful custody) Your written request must specify the alternative means and location.

7. 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 in which our professional judgement constitutes an emergency.

8. 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.

9. If we deny your amendment, you can place a written statement in our records disagreeing with our denial of your request.

10. 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 Centers operations. This can go back as far as six years, but not before April 14, 2003.

11. 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.

12. 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 please write or call (219-879-3283 ex.101) **Stacey Cook,** Executive Director, at: Samaritan Counseling Centers, 340 Commerce Square, Michigan City, Indiana 46360

13. 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.