(717) 560-9969
Fax (717) 560-9553

SAMARITAN COUNSELING CENTER
Healthy Minds. Strong Communities.

1803 Oregon Pike
Lancaster, PA 17601
www.scclanc.org

Consent for Services

Children Ages 11-13

Client Name:_____Date of Birth:_____Today's Date:_____

Parent(s) Name(s):_____

This form is called a Consent for Services (the "Consent"). Your child's health professional ("therapist") at Samaritan Counseling Center ("SCC" or the "Center") has asked you to read and sign this Consent before your child starts therapy. Please review the information. If you have any questions, please contact us at 717-560-9969.

Prior to beginning treatment, it is important for you to understand the Samaritan Counseling Center's approach to child therapy, especially when parents/guardians are involved in custody disputes. These situations often present risks to your child's confidentiality and progress during the course of his/her treatment.

One risk of child therapy involves disagreement among parents/guardians and/or disagreement between parents/guardians and therapist regarding the best interests of your child. If such disagreements occur, I will strive to listen carefully so that I can understand your perspectives and fully explain my perspective. We can resolve such disagreements or we can agree to disagree, so long as this enables your child's therapeutic progress. Ultimately, you will decide whether therapy will continue. If either of you decides that therapy should end, I will honor that decision, however I ask that you allow me the option of having a few closing sessions to appropriately end the treatment relationship.

Therapy is most effective when a trusting relationship exists between the therapist and the patient. Privacy is especially important in securing and maintaining that trust. It is the policy of the Samaritan Counseling Center to provide you with general information about treatment status. I will not share with you what your child has disclosed to me without your child's consent, with the exceptions of there being any danger to your child or another person.

BY SIGNING THIS CONSENT YOU AGREE that no party will ask me to release records to any party, nor to testify in court, whether in person, or by affidavit. I will also not share information based on any attempts by any party to gain advantage in any legal proceeding. In particular, you agree that in any such proceedings, no party will ask me to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena me or to refer in any court filing to anything I have said or done.

Note that such agreement may not prevent a judge from requiring my testimony, even though I will work to prevent such an event. If I am required to testify, I am ethically bound not to give my opinion about either parent/guardian's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, I will provide information as needed (if appropriate releases are signed or a court order is provided), but I will not make any recommendation about the final decision. Furthermore, if I am required to appear as a witness, the party responsible for my participation agrees to reimburse me at the rate of $150 per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs.

THE THERAPY PROCESS: Therapy is a collaborative process where your child and his/her therapist will work together to achieve defined goals. This means that your child will follow a defined process supported by scientific evidence, where your child and your therapist have specific rights and responsibilities. Therapy generally shows positive outcomes for individuals who follow the process. Better outcomes are often associated with a good relationship between a client and their therapist. To foster the best possible relationship, it is important you understand as much about the process before deciding to commit. Therapy begins with the intake process. First, you will review Samaritan Counseling Center's policies

and procedures, talk about fees, and identify emergency contacts. Second, you will discuss what to expect during therapy, including the type of therapy, the length of treatment, and the risks and benefits. If your therapist is practicing under the supervision of another professional at SCC, your therapist will tell you about their supervision and the name of the supervising professional. Third, you will form a treatment plan, including the type of therapy, how often your child will attend therapy, short- and long-term goals, and the steps your child will take to achieve them. Over time, your child and his/her therapist may edit the treatment plan to be sure it describes goals and steps needed to be taken. After intake, your child will attend regular therapy sessions at the therapist's office or through video, called telehealth. Participation in therapy is voluntary - you can stop at any time.

It is our belief that we can best assist your child if your treatment is coordinated with other health care professionals who are treating your child. In order to accomplish this, with your permission, we will initiate contact with your child's primary care provider or other pertinent providers.

Samaritan Counseling Center is a faith-aware organization and we have expertise in including client's faith/spiritual beliefs and practices as a part of the therapeutic process. It is our philosophy to work within the belief system of the client. The Center's therapists do not impose their personal beliefs upon clients and only include discussion of spirituality/religion/faith according to the expressed preference of the client.

CONFIDENTIALITY: Samaritan Counseling Center will not disclose your personal information without your permission unless required by law. If your therapist must disclose your personal information without your permission, your therapist will only disclose the minimum necessary to satisfy the obligation.

There are a few times that your therapist may not keep your personal information confidential.

- If your therapist believes there is a specific, credible threat of harm to someone else, they may be required by law or may make their own decision about whether to warn the other person and notify law enforcement. The term specific, credible threat is defined by state law. Your therapist can explain more if you have questions.
- If your therapist has reason to believe a minor is a victim of abuse or neglect (including the viewing of child pornography), they are required by law to contact the appropriate authorities.
- If your therapist believes that you are at imminent risk of harming yourself, they may contact law enforcement or other crisis services. However, before contacting emergency or crisis services, your therapist will work with you to discuss other options to keep you safe.

There may be times where a family member participates in therapy to assist in your child's treatment. These persons would not be considered a patient, and therefore would not need to consent to treatment, would not be given a diagnosis or treatment plan, nor would they have any right to access your child's chart without your written consent.

Please remember that in order to bill your insurance company for services, information must be provided to your insurer. In most cases, this information is the diagnosis code for your treatment here but an insurer, as the payor, may request additional information, such as a treatment plan or progress notes. We release the minimum amount of information required for compliance. In situations such as worker's compensation or an auto accident claim, your record from each session must accompany each claim for each date of service. Like Samaritan Counseling Center, your insurer must comply with privacy practices as a part of the Health Insurance Portability and Accountability Act (HIPAA).

FEES AND PAYMENT FOR SERVICES: All fees for services received at the Samaritan Counseling Center are your responsibility. Since insurance coverage is variable, SCC cannot guarantee what services will be covered by any insurance plan. SCC requests that you contact your insurance company for benefit information related to outpatient mental health.

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If SCC is a contracted provider with your insurance company, a co-pay and/or co-insurance and/or deductible amount will be expected at the time of each session. Co-pays/co-insurance/deductibles are determined by your insurance company and your plan. If your payment is determined to be incorrect upon receipt of the Explanation of Benefits from the insurance company, you are responsible for any underpayment; SCC will refund any overpayments. Clients are responsible for any annual deductible. Please obtain co-pay, co-insurance, deductible and mental health benefits information from your insurance company prior to the first appointment.

If SCC is not a contracted provider with your insurance company, payment in full will be expected at the time of each session. An itemized receipt will be given to you at each session for submission to your insurance company. Please refer to the fee schedule:

SERVICE	**FEE**
Adult Initial Evaluation	$160.00
Child or Family Initial Evaluation	$170.00
Adult Ongoing Session (38-52 minutes)	$110.00
Child or Family Ongoing Session (38-52 minutes)	$120.00
Abbreviated session (greater than 16 minutes)	$80.00
Extended session (greater than 53 minutes)	$140.00

Ancillary Services: $100 per hour. Not billable to insurance (see above).

Vouchers from Partner Churches are worth one session – session can be one initial evaluation or one ongoing session – or have a service value of $100. No refunds are made for unused portions of vouchers.

We accept Mastercard/Visa/Discover/AmericanExpress, check made payable to Samaritan Counseling Center or cash. A $15 service charge will be levied on all checks returned by a bank for insufficient funds.

Samaritan Counseling Center requests that you keep a valid credit or debit card on file through this patient portal (see the Payment Authorization Form). This card will be charged for the amount due at the time of service and for any fees you may accrue unless other arrangements have been made with the practice ahead of time. It is your responsibility to keep this information up to date, including providing new information if the card information changes or the account has insufficient funds to cover these charges.

NO-SHOW AND LATE CANCELLATION FEES: If you are unable to attend therapy, you must contact Samaritan Counseling Center or your therapist at least 24 hours before your session. This can be accommodated by speaking with someone or leaving a voice mail. Otherwise, you may subject to fees. For cancellations or reschedules made with less than 24 hours notice or for a missed appointment, clients will be charged $40. If two or more appointments are missed, cancelled or rescheduled with less than 24 hours notice, clients will be charged $80. Insurance does not cover these fees. Unforeseen emergency situations will be taken into account.

BALANCE ACCRUAL: Full payment is due at the time of your child's session. If you are unable to pay at that session, discuss this with your therapist. Any balance due will continue to be due until paid in full. If necessary, your balance may be sent to a collections service.

FEE SUBSIDIES: Thanks to Samaritan Counseling Center's generous donors, in the case of special financial need, a subsidized fee may be arranged with the therapist as funds are available. Payment of the client's portion of the fee is to be made at each session.

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ADMINISTRATIVE FEES: Your child's therapist may charge administrative fees for requested services beyond the typical standard of care such as (but not limited to) records review from another provider or school, writing a letter or report at your request; or consulting with another healthcare provider or other professional outside of normal case management practices. These services are billed directly to you at $100 per hour and are not reimbursable by your insurance company. Payment is due in advance.

EMERGENCIES: The Center does not provide emergency services. If a client has an urgent concern, that client's therapist will try to schedule an appointment with the client as soon as possible. The Crisis Intervention Center (717-394-2631) or your local emergency room are available for emergencies.

TERMINATION: If a client makes the decision to terminate counseling, Samaritan Counseling Center requests that a termination session be scheduled with your therapist. This is to allow time to finish the therapeutic process and to provide adequate aftercare.

CONSULTATION, EDUCATION AND SUPERVISION: Relevant material from the counseling sessions may be discussed with professional staff and consultants for consultation, education, or supervision purposes. All information will be handled professionally and confidentially.

RECORD KEEPING: Samaritan Counseling Center is required to keep records about your child's treatment. These records help ensure the quality and continuity of your care, as well as provide evidence that the services your child receives meet the appropriate standards of care. Your child's records are maintained in an electronic health record provided by TherapyNotes. TherapyNotes has several safety features to protect personal information, including advanced encryption techniques to make personal information difficult to decode, firewalls to prevent unauthorized access, and a team of professionals monitoring the system for suspicious activity. TherapyNotes keeps records of all log-ins and actions within the system.

IN-PERSON VISITS & SARS-CoV-2 ("COVID-19"): When guidance from public health authorities allows and your therapist offers, the session can be in-person. If you attend therapy in-person, you understand and agree:

- You can only attend if you are symptom-free (For symptoms, see: https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html)
- To move your appointment to a virtual appointment if you have traveled to a country or to a state identified for quarantine within the last 14 days.
- If you are experiencing symptoms, you will switch to a virtual appointment or cancel. If you need to cancel, you will not be charged a late cancellation fee.
- You will wash or sanitize your hands upon entering the building.
- During times of medium to high risk of contagious disease you will adhere to appropriate social distancing measures at all times.
- During times of medium to high risk of contagious disease you will wear a mask in all general areas of the office, including the waiting room and hallways. If you are requested to wear a mask, you agree to do so.
- Per CDC guidelines (https://www.cdc.gov/coronavirus/2019-ncov/your-health/quarantine-isolation.html), if you have been exposed to someone who tests positive for COVID-19:
    - you will inform your therapist and switch your appointment to virtual if you have not received your vaccinations and booster. If you do not become symptomatic, you may begin in person sessions after 5 days.
    - you may attend sessions in person if you have received your vaccinations and booster.

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SCC may change the above guidelines if additional local, state or federal orders or guidelines are published. If that happens, your therapist will discuss any necessary changes.

SCC has taken steps to reduce the risk of spreading the virus within the office. Please let us know if you have questions about these efforts.

- Seating throughout the building has been arranged to allow for appropriate physical distancing.
- Restroom soap dispensers are maintained and everyone is required to sanitize or wash their hands upon entry to the building.
- Hand sanitizers that contain at least 60% alcohol are available at each entrance, at the reception counter, and in every office and meeting room.
- Credit card pads, pens and other areas that are commonly touched are thoroughly sanitized after each use.
- Physical contact is not permitted.
- Tissues and trash bins are easily accessed.
- Common areas are thoroughly disinfected each day.

You understand that SCC is committed to keeping you, SCC staff and all of our families safe from the spread of this virus. If you show up for an appointment and your therapist or other SCC staff believe that you have a fever or other symptoms, SCC will require you to leave the office immediately. Your therapist can follow up with services by Videotherapy as appropriate.

SCC may be mandated to report to public health authorities if you have been in the office and have tested positive for infection. If so, your therapist may make the report without your permission, but will only share necessary information. Your therapist will never share details about your visit. Because the COVID-19 pandemic is ongoing, your ability to meet in person could change with minimal or no notice. By signing this Consent, you understand that you could be exposed to COVID-19 if you attend in-person sessions. If a member of the practice tests positive for COVID-19, you will be notified. If you have any questions, or if you want a copy of this policy, please ask.

TELEHEALTH SERVICES: Videotherapy services involves the delivery of health care services using electronic communications, information technology or other means between a health care provider employed by or otherwise contracted with Samaritan Counseling Center 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.
To use telehealth, you need an internet connection and a device with a camera for video. Your child's therapist or the intake staff can explain how to log in and use any features on the telehealth platform. If telehealth is not a good fit for you, your therapist will recommend a different option. There are some risks and benefits to using telehealth:
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 child's Provider may not be sufficient to allow for appropriate clinical decision

making by the Provider.

- The inability of your child's 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 your child.
- Your child's Provider may not able to provide clinical treatment for your particular condition via VideoTherapy and you may be required to seek alternative care.
- Delays in clinical evaluation/treatment could occur due to failures of the video technology.
- Security protocols or safeguards could fail causing a breach of privacy.
- Given regulatory requirements, your child's Provider's treatment options may be limited.

Additional Information

- You must have a webcam or a smartphone to utilize Videotherapy services.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be in a quiet, private space that is free from distractions.
- Do not use video or audio to record your session unless you ask your Provider for their permission in advance.
- It is important to be on time. If you need to cancel or change your Videotherapy session, you must notify the Provider at least 24 hours in advance. Late cancel/missed appointment charges may apply.
- In the event of technical problems, the Provider will contact you via phone number on file.
- Please provide the contact information for at least one emergency contact.

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

- 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.
- I understand that while the use of Videotherapy may provide potential benefits to my child, as with any clinical care service no such benefits or specific results can be guaranteed. My child's condition may not be cured or improved, and in some cases, may get worse.
- It is my duty to inform my Provider of other in-person or electronic interactions regarding my child's care that I may have with other health care providers.
- I understand that my child's 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.
- A variety of alternative methods of medical care may be available to my child, and that I may choose one or more of these at any time. My Provider has explained the alternatives to my satisfaction.
- I understand that the same confidentiality and privacy protections that apply to my child's other health care services also apply to these Videotherapy Services.
- I agree and authorize my child's Provider and Center to share information regarding the Videotherapy session with other individuals for treatment, payment and health care operations purposes as allowed by law.
- 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 child's Provider.

COMPLAINTS: Client satisfaction and quality of care are of utmost importance at Samaritan Counseling Center. Clients who have a complaint or would like to express concerns are encouraged to discuss the issue directly with their therapist. Clients may also contact the Executive Director, Steven Schedler, at 717-560-9969, ext. 252, or the Chair of the Board of Directors in care of Samaritan Counseling Center, 1803 Oregon Pike, Lancaster, PA 17601 in an envelope marked

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"Confidential". The Executive Director or Chair of the Board of Directors will respond to your complaint, in writing, within two weeks of receiving your complaint. The SCC will not retaliate against any person for filing a complaint.
If you feel your Provider has engaged in improper or unethical behavior, you can talk to them, or you may contact the licensing board that issued your Provider's license, your insurance company (if applicable), or the US Department of Health and Human Services.

Samaritan Counseling Center locations are smoke-free and weapons-free (knives, firearms, etc.) environments.

ACKNOWLEDGEMENT: My signature on this document represents that I have received the Consent for Services form and that I understand and agree to the information therein. Further, I consent to use an electronic signature to acknowledge this agreement.

Signature:_____Today's Date:_____

Printed Name:_____

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Client Information Form

Client First Name:_____ Middle Name:_____ Last Name:_____

Preferred Name:_____ Date of Birth:_____

Address Line 1:_____

Address Line 2:_____

City/State/Zip:_____

Mobile Phone:_____ Check box if voice mail OK: ☐

Home Phone:_____ Check box if voice mail OK: ☐

Work Phone:_____ Check box if voice mail OK: ☐

Other Phone:_____ Check box if voice mail OK: ☐

Email Address: _____

Would you like email reminders of your appointments? Yes ☐ No ☐

Administrative Sex: Male ☐ Female ☐

Gender Identity:

- ☐ Male
- ☐ Female
- ☐ Transgender Male/Trans Man/FTM
- ☐ Transgender Female/Trans Female/MTF
- ☐ Genderqueer, neither exclusively male nor female
- ☐ Additional gender category or other, please specify:_____
- ☐ Choose not to disclose

Sexual Orientation:

- ☐ Lesbian, gay or homosexual
- ☐ Straight or heterosexual
- ☐ Bisexual
- ☐ Something else, please describe:_____
- ☐ Unknown
- ☐ Choose not to disclose

Race:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White
- ☐ Choose not to disclose

Language(s):_____

Marital Status: Married ☐ Single ☐ Other ☐

Employment: Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Unemployed/Other ☐

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Client History Form

Client Name:_____Date of Birth:_____Today's Date:_____

Why are you seeking help now?
What is happening or is different? What stressors do you have? What do you hope will be different by seeking help?

Please give more details about the issue you named above:
When did it start? How often does it happen? How does it affect your life? How have you dealt with it so far?

Have you ever experienced similar or other mental health symptoms before?
If so, what was your experience like? When did it happen? Did you get help?

Has anyone in your family ever experienced mental health or substance use issues?
If so, who was it? Did they seek help or get a diagnosis? What was it like for them? What was it like for you?

Do you have any current or prior medical issues?
If so, what was/is it? Have you seen a doctor or other healthcare professional for it? What recommendations or treatment did you have? Is there any family history of disease?

Are you currently prescribed any medications?
If so, please list the name, dosage, how often you take it, and the prescriber for each medication.

Do you now, or have you ever, used alcohol, tobacco, recreational drugs, or prescription medication other than as prescribed?
If so, which? When did you start, how often did/do you use, and how long did this occur? Please list each substance separately.

Who is in your family? What is your relationship with them like?
Please list all individuals you consider to be a part of your family. For those who are not part of your family of origin (such as significant others), please include the duration of your relationship.

What social activities and relationships do you engage in?
What important social relationships do you have? Do you belong to any social clubs or organizations? How do you like to spend your leisure time?

What spiritual practices and cultural influences are important to you?
Do you belong to a religious, faith, or spiritual community? What other cultural groups do you identify with? How do you celebrate culture and spirituality in your life?

What was life like as you were growing up, both at home and in school?
Did you meet developmental milestones on time or experience any delays? What were your friends like when you were younger? What was school like for you?

What significant educational and work/volunteer experiences have you had?
What is the highest level of education you have completed? Are you currently employed? If so, where and for how long? What other work and educational experiences have you had (such as a stay-at-home parent or semester abroad)? Are you satisfied with your current employment and education?

Do you have any current or prior legal issues?
Were you ever arrested or charged with a crime or misdemeanor? Do you have any involvement with the civil courts, such as a lawsuit or family law matter? If so, please describe them.

What strengths and abilities are you bringing to sessions? What needs or preferences do you have that will help us be successful?
What coping skills have been working for you so far? What is important to know that will help make our time more effective for you?

What else is important to know about you?

Samaritan Counseling Center
1803 Oregon Pike, Lancaster PA 17603 | 717-5609969
Child and Youth Additional Information Form

Client's Name Date of Birth Age Grade

Personal Completing the Form Relationship to Child

Is this child/youth your biological, adopted, step, foster, other?

Who is the child/youth's legal guardian/s? If there are more than one guardian/parent, are the child/youth's legal guardians or parents married? If divorced or separated, is there a legal custody agreement/order? *If there is a legal custody agreement/order this must be provided before the first counseling session.*

Describe the child/youth's overall development including the approximate age when they began walking, talking, and toilet training, as well as the general speed at which they have developed, i.e. - slow, normal, rapid. Please include any developmental history that you would consider pertinent to their current presenting issues.

Please provide the child/youth's pediatrician name and place of practice. Have you discussed your concerns with them and/or have they been notified of the child/youth's appointment here?

Has the child/youth every experienced any traumatic events such as being physically or sexually abused, witnessing physical or sexual abuse or another person, emotional or physical neglect, loss of a parent or guardian, etc.? If so please describe.

Has this child/youth ever previously seen to a mental health professional? If so please provide the age they were at the time of service and the purpose of treatment.

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Client Contacts Form

Client Name:_____ Date of Birth:_____ Today's Date:_____

Contact Name: _____

Company Name:_____

☐ Emergency Contact ☐ Guardian ☐ Primary Care Physician

Relationship:_____ Date of Birth (if known):_____

Contact Address Line 1:_____

Contact Address Line 2:_____

Contact City/State/Zip:_____

Mobile Phone:_____ Home Phone:_____ Work Phone:_____

Fax:_____ Email Address: _____

Contact Name: _____

Company Name:_____

☐ Emergency Contact ☐ Guardian ☐ Primary Care Physician

Relationship:_____ Date of Birth (if known):_____

Contact Address Line 1:_____

Contact Address Line 2:_____

Contact City/State/Zip:_____

Mobile Phone:_____ Home Phone:_____ Work Phone:_____

Fax:_____ Email Address: _____

Samaritan Counseling Center

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717-560-9969

Notice of Privacy Practices

Steven Schedler, Executive Director
sschedler@scclanc.org

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a copy of this privacy notice
- Get a list of those with whom we've shared your information
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Provide mental health care
- Discuss appointments, treatment or goals with those you choose

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Comply with the law
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal action

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Most sharing of psychotherapy notes

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety
- Reporting of impaired drivers

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- We will never share any substance abuse or HIV disclosures or treatment records without your written permission.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

SAMARITAN COUNSELING CENTER

1803 OREGON PIKE • LANCASTER, PA 17601 • 717-560-9969 • FAX 717-560-9553

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have had the opportunity to review the **Notice of Privacy Practices** of the Samaritan Counseling Center. I understand that the terms of this Notice may change from time to time, in which case I will be notified of such changes, either verbally or in writing, and, upon my request will be provided the opportunity to review the new Notice.

I understand that I have the right to request that the Samaritan Counseling Center restrict the use or disclosure of protected health information for carrying out treatment, payment and/or health care operations. I also understand that the Samaritan Counseling Center is not required to agree to any restriction; however, if the requested restrictions are agreed to by the Samaritan Counseling Center, those restrictions are binding.

In addition, I understand that the Samaritan Counseling Center may make treatment conditional on my signing this Consent.

Finally, I understand that I have the right to revoke this Consent, in writing, at any time, except to the extent that the Samaritan Counseling Center has acted in reliance hereon.

By my signature below, I give my consent to the Samaritan Counseling Center to use and disclose, for the purpose of carrying out treatment, payment, and/or health care operations, protected health information in reference to:

Client Name	Date of Birth	Relationship of Person Completing this Form to Client Listed (Self, Parent, Guardian, etc.)

Client signature (or parent/guardian signature if client is a minor) Date

***Signature of minor client, if minor is 14 years or older** Date

Staff Signature Date

My signature above verifies that the Client received adequate explanation to make an informed decision

Restrictions: _____

Comments: _____ _____

Client Initials

(717) 560-9969
Fax (717) 560-9553

SAMARITAN COUNSELING CENTER
Healthy Minds. Strong Communities.

1803 Oregon Pike
Lancaster, PA 17601
www.scclanc.org

Client Insurance Form

Client Name:_____ Date of Birth:_____ Today's Date:_____

☐ I do not have or do not want to use insurance benefits. I will be responsible for all charges related to the services rendered.

Insurance Company:_____

Member ID:_____ Group Number:_____

Policy Holder Name:_____ Date of Birth:_____

Your relationship to the Policy Holder: _____

If you have a secondary insurance policy, please complete the following:

Insurance Company:_____

Member ID:_____ Group Number:_____

Policy Holder Name:_____ Date of Birth:_____

Your relationship to the Policy Holder: _____

Acknowledgement

I authorize Samaritan Counseling Center to release information to the insurance companies provided on this form in order to submit insurance claims on my behalf. This authorization extends to the extent necessary to obtain payment for the services provided to me, and includes authorization to release information about mental health, substance use, or HIV diagnoses as required. In consideration of the services provided to me, I assign all benefits to Samaritan Counseling Center if accepted, and authorize my insurance companies, Medicare, or other third-party payers to make payments directly to Samaritan Counseling Center and its affiliates. I understand that I remain responsible for all amounts due by me, including (but not limited to) copays, coinsurance, deductible amounts, and all services not covered by my insurance plan (including those for which I fail to obtain prior authorization), and mutually agreed-upon services or fees that are deemed not medically necessary.

Signature:_____

Printed Name:_____

(717) 560-9969
Fax (717) 560-9553

SAMARITAN COUNSELING CENTER
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Lancaster, PA 17601
www.scclanc.org

Payment Authorization Form

Client Name:_____Date of Birth:_____Today's Date:_____

Payment Method Details

Payment Method: New Credit/Debit Card

Name on Card:_____

Card Number: _____

Card Expiration Date:_____Security Code:_____

Billing Address Line 1:_____

Billing Address Line 2:_____

Billing City/State/Zip:_____

Acknowledgement

The Samaritan Counseling Center may utilize my payment method(s) on file for any balances, including late cancellation and no-show fees, without additional authorizations.

Signature:_____

Printed Name:_____

SAMARITAN COUNSELING CENTER

1803 OREGON PIKE • LANCASTER, PA 17601 • 717-560-9969 • FAX 717-560-9553

CONSENT FOR USE OF EMAIL AND TEXT COMMUNICATIONS

I am consenting to email and text communications between myself and the Samaritan Counseling Center, with the following understanding:

Potential Risks:

- Information transmitted may not be sufficient for a clear understanding between parties.
- Unencrypted email or text communication is **not** a HIPAA compliant form of communication. The Samaritan Counseling Center does not have encryption capabilities to maintain the procedures and protocols necessary for secure communication via email or text. There may be issues beyond the control of the Samaritan Counseling Center that could cause a breach of privacy of your confidential information. With your signature, you are affirming that you understand and are agreeing that the Center cannot guarantee any safety of the information that is discussed with you over these types of communication.
- Under no circumstances can the Samaritan Counseling Center guarantee that any email or text communication will be confidential.

I understand that the following alternatives are available to me:

- A face-to-face appointment with the clinician.
- Communication via telephone.

I understand that I have the right to revoke this Consent, in writing, at any time, except to the extent that the Samaritan Counseling Center has acted in reliance hereon.

By my signature below, I understand that any communication via email or texting is not secure and that the Samaritan Counseling Center does not guarantee the privacy of any communication via these types of communication.

_____
Client Name

_____ _____ _____
Date of Birth of Client | Your relationship to Client (Self, Parent, Guardian, etc.). | If not Client, Print your Name

_____
Email Address

_____ _____
Client signature (or parent/guardian signature if client is a minor) | Date

_____ _____
***Signature of minor client, if minor is 14 years or older** | Date

_____
Email Address for minor 14 years or older (if different than email address above)

_____ _____
Therapist Signature* | Date

*My signature above verifies that the client received adequate explanation to make an informed decision.

Restrictions: _____

Verbal Authorization
The undersigned verify verbal authorization has been given. Please request client review form online for their informed consent.

Samaritan Counseling Center

1803 Oregon Pike ● Lancaster, PA 17601 ● 717-560-9969

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION FROM/TO PRIMARY CARE PHYSICIAN

Please read and complete all items

Client Name:_____

Address:_____ City, State, Zip:_____

Date of Birth:_____ Phone Number:_____

☐ I authorize the use/disclosure of health information about me as described below:
OBTAIN from or **RELEASE** to what organization:

Organization Name:_____ Phone:_____

Contact Name:_____ Fax:_____

Address:_____

City, State, Zip:_____

This authorization is for the purpose of Coordination of Care with Primary Care Physician.

- □ Initiation of Treatment Letter
- □ Summary of Treatment to Date
- □ Termination of Treatment Letter
- □ Discharge Summary
- □ Treatment Plan
- □ Verbal and Phone Communication
- □ Psychological Evaluation
- □ Medications
- □ Medical History
- □ Lab Reports
- □ Other_____

☐ I do NOT wish Samaritan Counseling Center to disclose my Health Information to my Primary Care Physician at this time.

I understand that the information in my health record will include information about behavioral or mental health services. It may also include information about treatment of alcohol or drug abuse or information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).

State and Federal Law protect the following information. If this information applies to you, please indicate if you would like this information released/obtained:

Alcohol, Drug or Substance Abuse Records	□ Yes	□ No
HIV Testing and Results	□ Yes	□ No

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.

I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected under the terms of this authorization.

I understand that I may revoke this authorization in writing at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Center. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization expires on_____ or one year after the date of execution, whichever comes first.

_____

Client signature (or parent/guardian signature if client is a minor or unable to consent) Date

If Parent/Guardian, Print Name:_____

_____

***Signature of minor client, if minor is 14 years or older** Date

If the patient is unable to consent or is a minor, complete the following. Patient is:

□ Minor □ Incompetent □ Disabled

Legal Authority:

□ Custodial Parent □ Legal Guardian □ Power of Attorney for Healthcare □ Authorized Legal Representative

If you have any questions, please call 717-560-9969.

DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

Relationship with the child: _____

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) has your child...	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** has your child ...						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes	☐ No	☐ Don't Know			
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes	☐ No	☐ Don't Know			
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes	☐ No	☐ Don't Know			
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes	☐ No	☐ Don't Know			
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes	☐ No	☐ Don't Know			
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes	☐ No	☐ Don't Know			

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 11–17

Name: _____ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**_____

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) have you...	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Been bothered by stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Worried about your health or about getting sick?	0	1	2	3	4	
II.	3.	Been bothered by not being able to fall asleep or stay asleep, or by waking up too early?	0	1	2	3	4	
III.	4.	Been bothered by not being able to pay attention when you were in class or doing homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than you used to?	0	1	2	3	4	
	6.	Felt sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Felt more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Felt angry or lost your temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or done more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual but still had a lot of energy?	0	1	2	3	4	
VIII.	11.	Felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Not been able to do things you wanted to or should have done, because they made you feel nervous?	0	1	2	3	4	
IX.	14.	Heard voices—when there was no one there—speaking about you or telling you what to do or saying bad things to you?	0	1	2	3	4	
	15.	Had visions when you were completely awake—that is, seen something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Had thoughts that kept coming into your mind that you would do something bad or that something bad would happen to you or to someone else?	0	1	2	3	4	
	17.	Felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Worried a lot about things you touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Felt you had to do things in a certain way, like counting or saying special things, to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** have you...						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes			☐ No		
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes			☐ No		
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes			☐ No		
	23.	Used any medicine without a doctor's prescription to get high or change the way you feel (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes			☐ No		
XII.	24.	In the last 2 weeks, have you thought about killing yourself or committing suicide?	☐ Yes			☐ No		
	25.	Have you EVER tried to kill yourself?	☐ Yes			☐ No		