Samaritan Counseling Center
1612 Genesee St.
Utica NY 13502
315-724-5173 Fax 315-724-5323
www.samaritancentermv.com

For Office Use: ***Date Received*** _____

Date Assigned _____

ALL INFORMATION IS CONFIDENTIAL

Last First MI Client's Name:		Gender: ❑ Male ❑ Female	Today's Date: / /
Home Address	City	State	Zip
Home Phone # ( ) ___OK to use and leave message	Work Phone # ( ) ___OK to use and leave message	*Cell Phone # ( ) ___OK to use and leave message	
Partner/Parent/Other Phone # ( ) ___OK to use and leave message	*E-Mail Address: ___OK to use and leave message		

* Cell phone, e-mail, or other forms of electronic or wireless communication are not considered to be secure.

Date of Birth: ____/____/____ Age:____	Ethnic Background: Asian American ___ Hispanic___	African American___ Caucasian___ Other:_____	Marital Status: Single ____ Divorced ____ Married ____ Separated ___ Widowed ___ Other ____

Please list parent/guardian and all other members of your household:

Name	Age	Date Of Birth	Gender	Relation to You	Occupation/Employer	Religion
				SELF		

WILL YOU BE USING INSURANCE? ☐ No ☐ Yes IF YES, PLEASE PROVIDE YOUR INSURANCE INFORMATION

Insurance Carrier _____Policy ID # _____

Name & Date of Birth of Policy Holder, if not the listed client: _____

Address/Phone of Policy Holder, if different from client address above: _____

PERSON RESPONSIBLE FOR THIS ACCOUNT (Client name or parent/guardian name if the above client is a minor)

Name: _____Relationship to Client:_____

PATIENT'S 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 Counseling Center 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 Center charges for canceled sessions when less than 24 hours notice is given. A $65.00 fee will be charged . There will be a $20.00 service charge on all returned checks.
I understand the policies as stated above. Signature_____ Date_____

PLEASE COMPLETE THE BACK OF THIS FORM

Are you presently seeing another counselor?	❑ Yes	❑ No
Have you had previous counseling or psychotherapy?	❑ Yes	❑ No
Have you had previous psychotherapy here at Samaritan Counseling Center?	❑ Yes	❑ No

Why are you seeking counseling now?

Are days or nights better for you? ❑ Day ❑ Night

If you are employed outside the home, who is your current employer? _____

What is the highest grade you completed in school?

❑ 8th grade or less ❑ Some high school ❑ High school ❑ Some college ❑ College graduate ❑ Post-graduate work

Do you attend church/place of worship now? Yes ☐ No ☐

Name of Group_____City_____

INCOME (**Gross income** including child support, alimony, pension, Social Security, rental, and investment income)	Monthly $ _____ Spouse's Monthly $ _____ Other household $ _____ **Total Monthly Income $ _____**

Are there any health conditions your counselor should be aware of to include any allergies? Yes ☐ No ☐ If yes, please describe.

Are you currently taking any medications? Yes ☐ No ☐ If yes, please list and give the reason.

_____

_____

Client's Primary Physician/ Provider: _____

Address: _____ Phone:_____

Do you need an accessible location for services? Yes ❑ No ❑

What is your primary language? _____ **Do you need a language interpreter Yes ☐ No ☐**

Location where you would like to be seen: Utica ___; Rome ___; Herkimer ___

EMERGENCY CONTACT

Please provide the name of someone that we could contact in case of a medical or psychiatric emergency.

Name:_____ Relationship: _____

Home Ph._____ Work Ph._____ Cell Ph._____

How did you learn of Samaritan Counseling Center?

Church/Pastor___ Insurance Co. ___ Friend___ Physician___ School___ Former Client___ Web Site ___

Other:_____

ACKNOWLEDGMENT OF REFERRAL

It is the practice of Samaritan Counseling Center to acknowledge and thank members of the professional community for their trust in referring persons to us. Your signature below gives us permission to make such contact by phone or letter.

Name of Referring Individual: _____

Street Address: _____ City _____ Zip _____

Your Signature:_____