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

Client's Name: Last First MI	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: African American___ Asian American ___ Caucasian___ Hispanic___ Other:_______________	Marital Status: Single ____ Divorced ____ Married ____ Separated ___ Widowed ___ Other ____

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

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

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**____________________________

<u>CANCELLATION & RETURN CHECK POLICIES</u>

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 (**<u>Gross income</u>** 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 ___

<u>EMERGENCY CONTACT</u>

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:____

<u>ACKNOWLEDGMENT OF REFERRAL</u>

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:____